

Dear Energy Employees Occupational Illness Compensation Program (EEOICP) Provider:

This manual is designed to be a source of the latest information regarding the Energy Employees Occupational Illness Compensation Program (EEOICP) policy and billing procedures. Computer Sciences Corporation (CSC), on behalf of the Department of Labor (DOL), will publish and mail Provider Bulletins to you as changes in program policy and billing procedures occur. We encourage you to read these bulletins and keep them with your manual.

We appreciate your interest in the EEOICP. If you have any questions about billing the program, you may contact a representative toll-free at 1-866-272-2682.

Sincerely,

Provider Relations  
Computer Sciences Corporation

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## **Background of Energy Employees Occupational Illness Compensation Program (EEOICP) Act**

The Energy Employees Occupational Illness Compensation Program (EEOICP) Act, administered by the Department of Labor's (DOL) Office of Workers' Compensation Program (OWCP), was established by Title XXXVI of the Floyd D Spence National Defense Authorization Act of 2000. The program provides a lump sum benefit payment to the beneficiary and survivor beneficiaries and medical benefits as compensation to awarded beneficiaries suffering from designated illnesses incurred as a result of their exposure to radiation, beryllium, or silica while working for the Department of Energy (DOE), its contractor, or subcontractors in the nuclear weapons industry.

This legislation also provides a lump sum benefit payment and medical benefits to uranium workers who were awarded benefits under section five of the Radiation Exposure Compensation Act (RECA).

Eligibility for benefits is determined by DOL, and the benefit payment is the responsibility of DOL.

Medical benefits include reimbursement for expenses related to the care and treatment of the beneficiaries accepted condition and other illnesses as a result of or directly associated with the diseases.

## **Department of Labor (DOL)/Computer Sciences Corporation (CSC) Functional Responsibilities**

The following outlines the responsibilities of DOL and CSC, the servicing contractor for the EEOICP.

### **DOL Responsibilities:**

- Determine beneficiary eligibility for benefits.
- Provide guidance for reimbursement of services rendered for eligible beneficiaries.
- Establish Program's medical policies and procedures.

**CSC Responsibilities:**

- Process energy related treatment inpatient/outpatient hospital and pharmacy bills.
- Process medical bill adjustments.
- Mail beneficiary and provider Remittance Advice (RA) explanations.
- Generate Resubmission Turnaround Documents (RTDs) to providers for correction of bill errors; receive RTDs from providers and enter corrected information into the system.
- Conduct provider workshops.
- Maintain a Provider Relations Unit that will assist providers with billing problems; publish updates for the provider community according to DOL policy.
- Maintain a Correspondence/Communication Unit to answer telephone inquiries on a toll-free lines and answer written inquiries.
- Enroll providers in the EEOICP.

**Eligibility**

When eligibility is determined and benefits have been awarded and are to be paid by the Energy Employees Occupational Illness Compensation Program (EEOICP), the beneficiary will receive a letter from the Department of Labor (DOL). The letter will indicate the beneficiary's covered condition(s), (ICD-9 Code(s) and description) under the EEOICP.

The beneficiary is requested to present this letter to his/her medical provider for verification of eligibility. Family members are not entitled to medical benefits under the program.

Medical treatment or service for the beneficiaries related to the accepted condition(s) are the only services covered.

The claims adjudication process begins with a requirement that a written claim for benefits be filed with DOL on or after July 31, 2001.

The EE-1 (**Claims for Benefits - Figure 1 - EE-1 (Front)**) form is requested to be submitted to insure the Office of Workers' Compensation Program (OWCP) has the basic factual information necessary to begin adjudicating the claim. The form provides information with respect to his or her identity, contract information, the type of illness being claimed, the location or type of employment, whether he or she is a member of the Special Exposure Cohort, has received an award letter under the Radiation Exposure Compensation Act (RECA) or filed a lawsuit regarding the claimed illness.

The EE-7 (**Medical Requirements – See Figure 3 - EE-7**) is required to elicit the type of medical evidence needed to enable OWCP to make this particular finding of fact. Medical evidence prepared by medical providers may be required. Documentation of a covered occupational illness is one of the elements that must be met to determine entitlement of benefits under the EEOICP.

<b>Claim for Benefits under Energy Employees Occupational Illness Compensation Program Act</b>		<b>U.S. Department of Labor</b> Employment Standards Administration Office of Workers' Compensation Programs																																							
Provide all information requested below. <b>DO NOT FILL IN SHADED AREAS</b> . Disclosure of your social security number is voluntary. Failure to disclose this number will not result in the denial of any right, benefit or privilege to which you may be entitled.																																									
<b>EMPLOYEE INFORMATION</b>			OMB No. _____ Expires: _____																																						
1. Name (Last, First, Middle Initial) _____	2. Social Security Number <div style="border: 1px solid black; padding: 2px; display: flex; justify-content: space-between;"> <span> </span><span> </span><span> </span><span> </span><span> </span><span> </span><span> </span><span> </span><span> </span><span> </span><span> </span><span> </span><span> </span><span> </span><span> </span><span> </span> </div>	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Telephone Number (    )    -																																						
4. Address (Street, Apt #, P.O. Box)  _____ (City, State, ZIP Code)	5. Date of Birth <div style="border: 1px solid black; padding: 2px; display: flex; justify-content: space-between;"> <span>Month</span><span>Day</span><span>Year</span> </div>	7. Dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____																																							
<b>ILLNESS BEING CLAIMED</b>																																									
8. Identify Diagnosed Condition(s) Being Claimed			9. Date of Diagnosis <b>FOR DOL USE ONLY</b>																																						
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><input type="checkbox"/> Cancer</td> <td style="width: 70%;">Specify Type</td> </tr> <tr> <td><input type="checkbox"/> Beryllium Sensitivity</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Chronic Beryllium Disease</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Chronic Silicosis</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other Lung Condition</td> <td>Specify Type</td> </tr> <tr> <td><input type="checkbox"/> Renal Disease</td> <td>Specify Type</td> </tr> </table>			<input type="checkbox"/> Cancer	Specify Type	<input type="checkbox"/> Beryllium Sensitivity		<input type="checkbox"/> Chronic Beryllium Disease		<input type="checkbox"/> Chronic Silicosis		<input type="checkbox"/> Other Lung Condition	Specify Type	<input type="checkbox"/> Renal Disease	Specify Type	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>Month</th> <th>Day</th> <th>Year</th> <th></th> <th></th> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>		Month	Day	Year																						
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<input type="checkbox"/> Renal Disease	Specify Type																																								
Month	Day	Year																																							
<b>EMPLOYMENT CLASSIFICATION</b>																																									
10. Identify location or type of employment (Mark any that apply):																																									
<table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> <b>Department of Energy Facility</b>  <small>This is defined as any building, structure or premise in which the activities of federal employees, contractors or subcontractors have been conducted by or on behalf of the Department of Energy.</small> </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> <b>Beryllium Vendor</b>  <small>This is defined as any privately operated entity engaged in producing or processing beryllium for sale or use by the Department of Energy.</small> </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> <b>Atomic Weapons Facility</b>  <small>This is defined as a privately-owned facility in which radioactive material has been processed for use by the United States in the manufacture of atomic weapons. (Excludes mining, milling, or transporting uranium ore.)</small> </td> <td style="vertical-align: top;"> <input type="checkbox"/> <b>Uranium Worker</b>  <small>This is defined as employment activity associated with the mining, milling or transportation of uranium ore for use in the manufacture of atomic weapons.</small> </td> </tr> </table>					<input type="checkbox"/> <b>Department of Energy Facility</b> <small>This is defined as any building, structure or premise in which the activities of federal employees, contractors or subcontractors have been conducted by or on behalf of the Department of Energy.</small>	<input type="checkbox"/> <b>Beryllium Vendor</b> <small>This is defined as any privately operated entity engaged in producing or processing beryllium for sale or use by the Department of Energy.</small>	<input type="checkbox"/> <b>Atomic Weapons Facility</b> <small>This is defined as a privately-owned facility in which radioactive material has been processed for use by the United States in the manufacture of atomic weapons. (Excludes mining, milling, or transporting uranium ore.)</small>	<input type="checkbox"/> <b>Uranium Worker</b> <small>This is defined as employment activity associated with the mining, milling or transportation of uranium ore for use in the manufacture of atomic weapons.</small>																																	
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<b>SPECIAL EXPOSURE COHORT</b>																																									
11. Prior to February 1, 1992, did you work at a gaseous diffusion plant in Paducah, Kentucky; Portsmouth, Ohio; or Oak Ridge, Tennessee? <input type="checkbox"/> YES If yes, which site(s) _____ <input type="checkbox"/> NO																																									
12. Prior to January 7, 1974, did you work at the Long Shot, Milrow, or Cannikin underground nuclear tests on Amchitka Island, Alaska? <input type="checkbox"/> YES If yes, which site(s) _____ <input type="checkbox"/> NO																																									
13. Are you a member of a group added to the Special Exposure Cohort by the Department of Health and Human Services? <input type="checkbox"/> YES List group designation _____ <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW																																									
<b>RADIATION EXPOSURE COMPENSATION ACT AWARD &amp; CIVIL LAWSUIT</b>																																									
14. Have you received an award letter under the Radiation Exposure Compensation Act? <input type="checkbox"/> YES If yes, submit a copy of your award letter <input type="checkbox"/> NO																																									
15. Have you filed a civil lawsuit regarding your claimed condition(s)? <input type="checkbox"/> YES If yes, submit a copy of court documentation <input type="checkbox"/> NO																																									
<b>EMPLOYEE DECLARATION</b>																																									
16. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided under the EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.  I hereby make a claim for benefits under the Energy Employees Occupational Illness Compensation Program Act and affirm that the information I have provided on this form is true. Furthermore, I authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Worker's Compensation Programs.																																									
Claimant Signature _____			Date _____																																						

**Figure 1 - EE-1 (Front)**

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**BENEFITS UNDER THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT**

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The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) provides for a lump sum payment of \$150,000 and medical benefits to covered employees suffering from designated illnesses incurred as a result of their exposure to radiation, beryllium, or silica while in the performance of duty for the Department of Energy and certain of its vendors, contractors and subcontractors. This legislation also provides for payment of compensation to certain survivors of these covered employees, as well as for a \$50,000 lump sum payment and medical benefits to individuals, or their survivor(s), who have been found eligible for compensation under the Radiation Exposure Compensation Act (RECA).

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**INSTRUCTIONS FOR COMPLETING FORM EE-1**

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Complete all items on the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. If the requested information is not submitted, the responsible party should explain the reason for the delay and indicate when the information will be forthcoming. Submit the completed claim form and all other pertinent documentation to the appropriate District Office administering the EEOICPA in the region where your most recent Energy employer is/was located.

***Illness Being Claimed***

**Item #8** — Identify the diagnosed condition(s) being claimed. If you have a claim for a cancer, unspecified lung condition or renal disease, you must list the particular diagnosis.

**Item #9** — List the date a qualified physician first diagnosed your claimed condition(s).

***Employment Classification***

**Item #10** — Check the box for the location and/or the type of work activities that best describes your employment situation. Mark all that apply. The Department of Energy has compiled a list of facilities categorized by location and employment designation. The list is available at the Department of Energy's web page <http://tis.eh.doe.gov>, or by contacting the OWCP District Office.

***Special Exposure Cohort***

**Items #11–12** — The Act allows for employees who have met particular criteria and have been employed at certain facilities to be designated as members of the Special Exposure Cohort. If you worked at any of the listed locations prior to the dates indicated, mark YES and identify the site name.

**Item #13** — The Act permits the Department of Health and Human Services (HHS) to include new groups of employees in the Special Exposure Cohort. If you can identify yourself as a member of a designated group that has been added to the Special Exposure Cohort, mark YES and describe the group in which you belong.

***Radiation Exposure Compensation Act Award & Civil Lawsuit***

**Item #14** — If you have been found entitled to an award under the Radiation Exposure Compensation Act, you may be eligible for additional payment under the EEOICPA. Please indicate whether or not you have received a notice of award under the RECA. If you mark YES, you will need to submit a copy of the award letter.

**Item #15** — Indicate whether you have filed a civil lawsuit in regard to your claimed condition. If you mark YES, provide copies of all court documentation.

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**PRIVACY ACT**

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In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (P.L. 106-398) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has received will be used to determine eligibility for, and the amount of, benefits payable under the EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office of Workers' Compensation and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under the EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue salary/administrative offset and debt collections actions required or permitted by the Debt Collection Act. (6) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision. This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the EEOICPA.

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**PUBLIC BURDEN STATEMENT**

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Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim form to this address. Completed claims are to be submitted to the appropriate regional District Office of Workers' Compensation Programs. Persons are not required to respond to the information collected on this form unless it displays a currently valid OMB number.

EE-1  
May 2001

**Figure 2 - EE-1 (Back)**

Medical Requirements under the Energy Employees  
Occupational Illness Compensation Program Act (EEOICPA)

U.S. Department of Labor  
Employment Standards Administration  
Office of Workers' Compensation Programs



OMB No.:  
Expires:

The information in this document is intended to inform an employee, survivor or physician of the medical evidence necessary to establish a diagnosis of the following conditions under the EEOICPA: **Beryllium Sensitivity, Chronic Beryllium Disease, Chronic Silicosis and Cancer**. Medical evidence may include narrative reports, physician notes, diagnostic test results, imaging studies, laboratory work-ups, pathology reports, operative reports, pulmonary function assessments, autopsy evaluations, death certificates, etc. The completed medical report package should be submitted to the appropriate District Office. Decisions regarding coverage under the EEOICPA are contingent on the submission of appropriate medical and factual evidence. This form provides information regarding medical requirements only. Maintain a copy of all documents for your records.

**GENERAL REQUIREMENTS**

*Any claim filed under the EEOICPA has to include a medical report(s) providing:*

- A history of the illness or condition
- A physical examination and its findings
- The clinical laboratory tests performed and discussion of the results
- A diagnosis (ICD-9 coded, if possible) and the date when it was first documented

**REQUIREMENTS FOR A DIAGNOSIS OF BERYLLIUM SENSITIVITY**

- Abnormal Beryllium Lymphocyte Proliferation Test (LPT) that has been performed on the blood or lung lavage cells

**REQUIREMENTS FOR A DIAGNOSIS OF CHRONIC BERYLLIUM DISEASE**

If the initial date of diagnosis was made **on or after January 1, 1993**, medical documentation must include an Abnormal Beryllium Lymphocyte Proliferation Test (LPT) and one or more of the following:

- Lung biopsy showing a process consistent with chronic beryllium disease
- A computerized axial tomography scan showing changes consistent with chronic beryllium disease
- A pulmonary function study or exercise tolerance test showing pulmonary deficits consistent with chronic beryllium disease

If the initial date of diagnosis was made **before January 1, 1993**, medical documentation must include at least three or more of the following:

- Characteristic chest radiograph or computed tomography denoting abnormalities
- A restrictive or obstructive lung physiology test or diffusion lung capacity defect
- Lung pathology consistent with chronic beryllium disease
- Clinical course consistent with chronic respiratory disease disorder
- Immunologic tests showing beryllium sensitivity (skin patch test or beryllium test)

**REQUIREMENTS FOR A DIAGNOSIS OF CHRONIC SILICOSIS**

One or more of the following:

- A chest radiograph, interpreted by a National Institute for Occupational Safety and Health certified B reader, confirming the existence of pneumoconiosis with a 1/1 ILO category or higher
- Results from a computer-assisted tomograph or other imaging technique consistent with silicosis
- A lung biopsy consistent with silicosis

**REQUIREMENTS FOR A DIAGNOSIS OF CANCER**

- The pathology report(s) (e.g. tissue biopsy or blood test) that forms the basis for the diagnosis of cancer and identifies the malignant neoplasm present
- A narrative report that addresses whether there are metastases present and the affected anatomic sites, as well as the presence of any cancer-related syndromes or other complications

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room SPS24, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim to this address. Completed claims are to be submitted to the appropriate regional District Office of Workers' Compensation Programs.

EE-7  
May 2001

**Figure 3 - EE-7**

## Sample Eligibility Letter – 1 Diagnosis

EMPLOYMENT STANDARDS ADMINISTRATION  
OFFICE OF WORKERS' COMPENSATION PROGRAMS  
DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL  
ILLNESS COMPENSATION  
FINAL ADJUDICATION BRANCH

September 19, 2001

Sean Doe  
P.O. Box 6854  
Cleveland, OH 86574

Claimant Name: Sean Doe  
Claimant SSN: 123-45-6789

Dear Mr. Doe:

As a beneficiary under the Energy Employees Occupational Illness Compensation Program Act you are entitled to medical benefits for treatment of your **Malig NEO Small Bowel: ICD-9 code 152,,**. Your entitlement to these benefits is retroactive to July 31, 2001. Covered medical services are payable in accordance with fee schedules and medical policy of the Energy Employees Occupational Illness Compensation Program (EEOICP). The policy includes coverage of medical appointments, hospitalizations, appliances, supplies and drugs that are prescribed by a qualified physician and approved by the EEOICP.

When you receive medical treatment you should show this letter to the medical provider you wish to designate as your treating physician and any other authorized medical provider who may treat you for your covered conditions. Most physicians, hospitals, durable medical equipment suppliers and other health care providers will bill the Energy Employees Occupational Illness Compensation Program directly so that you will not have to pay for medical treatment covered under the program. To bill directly, providers must be enrolled in the program. For information about enrollment and billing procedures, providers may contact the Program at the address and telephone number listed at the end of this letter.

**Note:** If the EEOICP pays less than the billed amount (in accordance with the fee schedule), you are not responsible for payment of the difference to a provider. Providers (and claimants) may submit appropriate documentation to the program's billing address. However, bills and requests for reimbursement must be sent to EEOICP within one year after the end of the calendar year in which your condition was accepted, whichever is later.

To request reimbursement of medical expenses associated with treatment of your accepted condition you are required to complete and submit the **EE-915 form, Claim for Medical Reimbursement Under Energy Employees Occupational Illness Compensation Program Act**. You should also complete and submit the **OWCP-957, Medical Travel Refund Request** form with appropriate receipts when seeking reimbursement for travel expenses covered under the program. Both the EE-915 and OWCP-957 forms (copies enclosed for your convenience) include instructions for when you should complete these forms and the documentation required to process your request for reimbursement.

All requests for reimbursement of covered treatment related expenses including travel are to be mailed to:

US Department of Labor  
Employment Standards Administration  
Energy Employees Occupational Illness Compensation Program  
P.O. Box 727  
Lanham-Seabrook, MD 20703-0727

If providers have questions regarding submission or payment of bills, or require any other medical bill program assistance, they may contact a representative toll-free at 1-866-272-2682.

Sincerely,

*Jane Person*  
Jane Person  
Hearing Representative

## Sample Eligibility Letter – Multiple Diagnosis

EMPLOYMENT STANDARDS ADMINISTRATION  
OFFICE OF WORKERS' COMPENSATION PROGRAMS  
DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL  
ILLNESS COMPENSATION  
FINAL ADJUDICATION BRANCH

September 19, 2001

Sean Doe  
P.O. Box 6854  
Cleveland, OH 86574

Claimant Name: Sean Doe  
Claimant SSN: 123-45-6789

Dear Mr. Doe:

As a beneficiary under the Energy Employees Occupational Illness Compensation Program Act you are entitled to medical benefits for treatment of your **colon cancer that has metastasized to the liver, bones, lymph nodes and soft tissue of the pelvis, hydronephrosis and loss of function of the kidneys. ICD-9 diagnosis code for your accepted conditions are: colon153.0; liver 197.7; bone 198.5; lymph node 202.0; pelvis 198.89; hydronephrosis 591; kidney disorder 593.9.** Your entitlement to these benefits is retroactive to July 31, 2001. Covered medical services are payable in accordance with fee schedules and medical policy of the Energy Employees Occupational Illness Compensation Program (EEOICP). The policy includes coverage of medical appointments, hospitalizations, appliances, supplies and drugs that are prescribed by a qualified physician and approved by the EEOICP.

When you receive medical treatment you should show this letter to the medical provider you wish to designate as your treating physician and any other authorized medical provider who may treat you for your covered conditions. Most physicians, hospitals, durable medical equipment suppliers and other health care providers will bill the Energy Employees Occupational Illness Compensation Program directly so that you will not have to pay for medical treatment covered under the program. To bill directly, providers must be enrolled in the program. For information about enrollment and billing procedures, providers may contact the Program at the address and telephone number listed at the end of this letter.

**Note:** If the EEOICP pays less than the billed amount (in accordance with the fee schedule), you are not responsible for payment of the difference to a provider. Providers (and claimants) may submit appropriate documentation to the program's billing address. However, bills and requests for reimbursement must be sent to EEOICP within one year after the end of the calendar year in which your condition was accepted, whichever is later.

To request reimbursement of medical expenses associated with treatment of your accepted condition you are required to complete and submit the **EE-915 form, Claim for Medical Reimbursement Under Energy Employees Occupational Illness Compensation Program Act.** You should also complete and submit the **OWCP-957, Medical Travel Refund Request** form with appropriate receipts when seeking reimbursement for travel expenses covered under the program. Both the EE-915 and OWCP-957 forms (copies enclosed for your convenience) include instructions for when you should complete these forms and the documentation required to process your request for reimbursement.

All requests for reimbursement of covered treatment related expenses including travel are to be mailed to:

US Department of Labor  
Employment Standards Administration  
Energy Employees Occupational Illness Compensation Program  
P.O. Box 727  
Lanham-Seabrook, MD 20703-0727

If providers have questions regarding submission or payment of bills, or require any other medical bill program assistance, they may contact a representative toll-free at 1-866-272-2682.

Sincerely,

*Jane Person*  
Jane Person  
Hearing Representative

## **Coverage**

Diseases covered include cancer caused by radiation, chronic beryllium disease, and chronic silicosis. Medical monitoring is provided for workers with beryllium sensitivity. Consequential injuries may be covered providing the diagnosis is an approved condition by the EEOICP.

## **Claims for Compensation**

The Department of Labor (DOL) Office of Workers' Compensation Program (OWCP) administers the adjudication of claims and payment of benefits under EEOICP Act. Employees may also work with three other departments which share some responsibilities:

- The DOE's Office of Worker Advocacy will help workers file compensation claims and list facilities where workers were exposed.
- The Department of Health and Human Services (HHS) will establish guidelines for calculating the amount of radiation received by employees alleged to have sustained cancer as a result of such exposure and determine whether such cancers are at least or not likely related to employment.
- The Justice Department will notify potential beneficiaries and submit evidence necessary for DOL's adjudication of claims under the EEOICP Act.

Claims forms are available on the department's website at [www.dol.gov](http://www.dol.gov). Beneficiaries can also pick them up at the EEOIC District Office in Seattle, Washington; Denver, Colorado; Cleveland, Ohio; or Jacksonville, Florida.

Forms will also be available at resource centers near major Energy Department facilities in Idaho Falls, Idaho; Portsmouth, Ohio; Paducah, Kentucky; Richland, Washington; Aiken, South Carolina; Espanola, New Mexico; Oakridge, Tennessee; Las Vegas, Nevada; and Denver, Colorado. Workers can get help filling out their claims at any of these locations.

## **Beryllium Sensitivity**

Exposure to beryllium dust may cause sensitization, an immune system response to beryllium. Individuals who are sensitized to beryllium have white blood cells in the blood or lungs that react to beryllium, but no symptoms of disease have become evident. Medical studies have shown that even small amounts of beryllium particles breathed deeply into the lungs may trigger this sensitivity in 2 to 5 percent of people exposed. In studies of people in certain occupations where exposure to beryllium was greatest (for example, studies of machinists in beryllium operations), this figure rises to as much as 10 to 14 percent. Currently, there is no available test to determine who is at risk for becoming sensitive to beryllium. Blood tests can only indicate those individuals already sensitized to beryllium.

Under the Energy Employees Occupational Illness Compensation Program (EEOICP), beneficiaries are entitled to annual medical examinations to confirm and monitor the extent and nature of beryllium sensitivity. The medical examination services include the following on an annual basis:

- Physical examination (CPT-4 Code: 99241 - 99245)
- Chest X-ray (CPT-4 Code: 71010 – 71030)
- CAT scan of the thorax (CPT-4 Code: 71250 – 71260)
- Pulmonary function studies (CPT-4 Code: 94060)  
(Pre/Post bronchodilator) (CPT-4 Code: 94060)
- Diffusing capacity studies (CPT-4 Code: 94720 – 94725)
- Exercising tolerance test (CPT-4 Code: 94620 – 94621)
- Complete blood count (CPT-4 Code: 85031)
- Multiple blood chemistries (CPT-4 Code: 80048 – 80053)
- Bronchoscopy (CPT-4 Code: 31622 – 31625)
- Beryllium skin patch test (CPT Code: 95044)
- Lymphocyte Proliferation Test (LPT)/Lymphocyte Transformation Test (LLT) (CPT-4 Code: 86353)

## Sample Letter – Beryllium Sensitivity

Claimant Name:  
Claimant SSN:

Dear

As a beneficiary under the Energy Employees Occupational Illness Compensation Program Act, you are entitled to medical examinations to confirm and monitor the extent and nature of your beryllium sensitivity, ICD-9 diagnosis code V81.4. It is important that the physician or other health professional who will administer tests use this diagnosis code on all bills submitted for payment on your behalf. This monitoring shall also include diagnostic testing to determine whether you have established chronic beryllium disease. Your entitlement to medical monitoring services is retroactive to xxxxxx.

These medical examination and monitoring services include an annual:

Physical examination (CPT-4 Code: 99241 - 99245)  
Chest X-ray (CPT-4 Code: 71010 – 71030)  
CAT scan of the thorax (CPT-4 Code: 71250 – 71260)  
Pulmonary function studies (CPT-4 Code: 94060)  
(Pre/Post bronchodilator) (CPT-4 Code: 94060)  
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Bronchoscopy (CPT-4 Code: 31622 – 31625)  
Beryllium skin patch test (CPT Code: 95044)  
Lymphocyte Proliferation Test (LPT)/Lymphocyte Transformation Test (LLT) (CPT-4 Code: 86353).

\*Codes represent the American Medical Association's Current Procedural Terminology (CPT –4) version.

When you receive medical services to monitor your beryllium sensitivity, you should show this letter to the physician or other health professional who will administer the tests. Your physician will choose which tests are the most appropriate to perform at a given time. Tests other than those indicated above will be considered for payment on a case by case basis. Reimbursement for these services as well as the cost of reasonable travel associated with these services is made in accordance with the fee schedules and medical policy of the Energy Employees Occupational Illness Compensation Program (EEOICP). If your travel is other than local (more than 150 miles roundtrip), prior-authorization must be obtained from your claims examiner for reimbursement for this travel. Most physicians will bill the EEOICP directly so that you will not have to pay for these services. To bill directly, providers must be enrolled in the program. For information about enrollment and billing procedures, providers may contact the Program at the address and toll-free telephone number listed on this letter.

Note: If the EEOICP pays less than the billed amount (in accordance with the fee schedule), you are not responsible for payment of the difference to a provider. Providers (and claimants) may submit requests for reconsideration of fee determinations in writing, with accompanying documentation to the address supplied at the end of this letter.

In addition to paying your medical providers directly, the EEOICP will reimburse you for the cost of covered services that you have personally paid, providing that you submit appropriate documentation to the program's billing address. Bills and requests for reimbursement must be sent to EEOICP within one year after the end of the calendar year in which your condition was accepted, whichever is later.

To request reimbursement of specific medical expenses associated with the medical monitoring of beryllium sensitivity which you paid for directly, you are required to complete and submit the enclosed EE-915 form, "Claim for Medical Reimbursement Under Energy Employees Occupational Illness Compensation Program Act." Medical providers use other forms to directly bill the EEOICP. To request reimbursement of travel expenses covered under the program, you should complete and submit the OWCP-957 "Medical Travel Refund Request" form with the appropriate receipts. Both the EE-915 and OWCP-957 forms are enclosed for your use and include instructions on what documentation must accompany the form in order to process the bills for reimbursement.

All requests for additional forms and reimbursement of your covered medical expenses including travel are to be mailed to:

U.S. Department of Labor  
Energy Employees Occupational Illness Compensation Program  
P.O. Box 727  
Lanham-Seabrook, MD 20703-0727

If providers have questions regarding submission or payment of bills, or require any other medical bill program assistance, they may contact a representative, toll-free at 1-866-272-2682.

Sincerely,

## Provider Enrollment Procedures

Many categories of providers are eligible for reimbursement of services for the Energy Employees Occupational Illness Compensation Program (EEOICP). Among these are hospitals, physicians, clinics, pharmacies, durable medical equipment and oxygen suppliers, home nursing services, laboratories, and ambulance services. The services provided must be *directly associated* with the Beneficiary's accepted Energy condition.

Providers must be enrolled by the Department of Labor (DOL) to be reimbursed for covered services rendered under the EEOICP.

Enrollment in the program as an eligible provider requires the submission of a completed EEOICP Provider Enrollment Form (CM-1168). Eligible providers are assigned a six-digit DOL provider number. **This number must appear on each bill submitted to the program for payment.**

Interested providers may enroll in the EEOICP by submitting an application to the following address:

Provider Enrollment  
Energy Employees Occupational Illness Compensation Program  
P.O. Box 727  
Lanham-Seabrook, MD 20703-0727

Any subsequent changes in name, address, or employer (tax) ID number must be submitted in writing to the above address. You must ensure that any such changes are reported promptly. The accuracy of Form 1099 earnings data reported to you and to the Internal Revenue Service (IRS) depends on the information you provide to us.

When a provider is enrolled in the EEOICP and assigned a six-digit provider number, this information is retained permanently. Therefore, providers do *not* need to send a copy of their enrollment form with submitted bills.

Providers must submit all claims to the servicing contractor in Lanham, Maryland, for processing and payment. Payment checks or electronic funds transfer transactions are issued by the U.S. Treasury Department. Remittance Advice (RA) statements are generated and mailed from Lanham, Maryland.

Provider's name, address, and provider number *must* be on *all* accepted program billing forms and correspondence to expedite processing. The provider's name, address, and provider number should appear *exactly* the same on every billing form submitted and be identical to the information on file with DOL. If the provider number is missing, the bills will be returned to the provider.

## Sample Provider Enrollment Letter

### U.S. Department Labor

Employment Standards Administration  
Office of Workers' Compensation Programs

Please Reply To:

U.S. Department of Labor  
Employment Standards Administration  
Energy Employees Occupational Illness Compensation Program  
P.O. Box 727  
Lanham-Seabrook, Maryland 20703-0727

Call Toll Free: 1-866-272-2682

Dear Provider:

This letter concerns provider enrollment requirements under the Energy Employees Occupational Illness Compensation Program (EEOICP). The Department of Labor (DOL) determines eligibility for workers' compensation claims made under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). Under the program, a claimant found eligible for medical benefits is issued a letter that identifies the accepted condition(s) and describes medical coverage. Medical coverage includes reimbursement for reasonable and customary expenses related to the treatment of the accepted condition(s). In order to facilitate processing of medical bills submitted on behalf of an eligible employee, a provider must be issued a unique six-digit Provider ID number.

Attached is a Provider Enrollment Form for you to complete so that a Provider ID number can be assigned to your facility. The Provider Enrollment form must be signed by a representative of your firm. DOL is unable to accept to a mailing address if it is listed only as a P.O. Box; thus please ensure that a street address is included on the form. The Debt Collection Improvement Act of 1996 requires that payments made from the Federal government be sent by electronic funds transfer (EFT). Therefore, payments made to you for medical services rendered for the EEOICP must be sent by EFT directly from the U.S. Treasury Department to your bank account.

Please complete and return the enclosed Provider Enrollment and ACH Vendor Payment forms to:

**U.S. Department of Labor**  
**Employment Standards Administration**  
**Energy Employees Occupational Illness Compensation Program**  
**P.O. Box 727**  
**Lanham-Seabrook, Maryland 20703-0727**

After your enrollment application has been processed, you will be notified by letter of your Provider ID number. A provider-billing manual will accompany the notification letter. **Please read the manual carefully before submitting bills to the EEOICP; specific required coding requirements are outlined which, if not followed, could result in delay in the processing of the bills, and/or denial.**

Please Do Not Bill the EEOICP Until You Have Received Your Unique Six-Digit ID Number. If you have any questions, please call toll-free, 1-866-272-2682, Monday through Friday, 8:15 A.M. to 4:45 P.M., Eastern Time.

Sincerely,

Correspondence/Communications Representative  
Medical Bill Operations Department

Attachment (s)

## Provider Enrollment Form (Instructions)

### Objective



After completing this section you should be able to accomplish the following:

- Fill out the Provider Enrollment form.

**Note: Required fields are shaded.**

Block #	Block Description	Instructions or Comments
I.	Are you applying for a new enrollment or updating your record with our program?	Enter a checkmark in the appropriate box. <ul style="list-style-type: none"> <li>• New Enrollment</li> <li>• Update Request</li> <li>• Updating your record (Enter your Provider #)</li> </ul> <b>Note: Complete the appropriate sections only.</b>
II.	Check the provider type below that most closely describes the medical service(s) you provide.	Check your provider type: <ul style="list-style-type: none"> <li>• Physician, Private Practice</li> <li>• Physician Corporation or Group Practice</li> <li>• Hospital</li> <li>• Durable Medical Equipment</li> <li>• Pharmacy</li> <li>• Pulmonary Rehabilitation</li> <li>• Skilled Nursing Facility, Nursing Home, Hospice or Home Health Agency</li> <li>• Ambulance, Other (If other, please explain)</li> </ul>
III.	Will you accept referrals?	Check Yes or No.
IV.	Please complete one of the following three boxes (A, B, or C).	You only have to complete one of the three boxes (A, B, or C).
A.	Physician Provider (Private Practice)	Enter the information if you are a Physician with a Private Practice only.
	Name	Type or print first name.
	M.I.	Type or print middle initial.
	Last	Type or print last name.
	M.D.	
	D.O.	
	Tax I.D. Number	Type or print Tax I.D. number.
	Specialty	Type or print Specialty.
	Board Certified	Are you board certified? Check Yes or No.
	Social Security Number	Type or print Social Security Number.
	License Number	Type or print License Number.
	License Expiration Date	Type or print License's Expiration Date.
B.	Physician Provider (Corporation or Group Practice)	Enter the information if you are in a Corporation or Group Practice only.
	Name (Corporation)	Type or print name of the Corporation or Group Practice.
	Tax ID Number	Type or print Tax ID number.
	Specialty	Type or print Specialty.
	For each physician billing under your provider number, list the following:	Continue on separate sheet, if necessary.
	Name	Type or print Corporation or Group Practice name.
	Board Certified	Check Yes or No.
	Social Security Number	Type or print Social Security Number.
	License Number	Type or print License Number.

Block # contd.	Block Description contd.	Instructions or Comments contd.
C.	Non-Physician Provider (Hospital, Durable Medical Equipment Supplier, Pharmacy, Pulmonary Rehabilitation Clinic, Skilled Nursing Facility, Nursing Home Facility, Home Health Agency, Ambulance, Other	Enter the information if you are a Non-Physician Provider only.
	Official name of your Facility or Agency	Type or print name of your Facility or Agency.
	Billing name as it will appear on your bill.	Type or print name as it appears on your bill.
	Tax ID Number	Type or print Tax ID Number.
	Medical service you provide	Type or print type of Medical service you provide.
	License Number	Type or print License Number.
	License Expiration Date	Type or print expiration date of your license.
V.		
A.	Local address and telephone number	
	Street Number and Name	Type or print Street Number and Street Name.
	City	Type or print City.
	State & Zip Code	Type or print State and zip code.
	Area Code	Type or print area code of your phone number.
	Number	Type or print phone number.
B.	Billing or mailing address – indicate “same” if identical to A.	This is where your checks and remittance reports will be sent.
	Street Number and Name	Type or print Street Number and Name.
	City	Type or print City.
	State & Zip Code	Type or print State and Zip Code.
VI.	Notice: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal laws.	
	Signature (Provider or Representative and Title)	Write your name if you are the Provider. If you are a Representative, write your name and title.
	Date	Type or print date the form is signed.

Provider Enrollment Form		<b>U.S. Department of Labor</b> Employment Standards Administration Office of Workers' Compensation Programs																																										
We are authorized by law (30 USC 901-945 et seq. and 20 CFR 725.703) and Public Law 106-398 and 20 CFR 30.701 to collect the information requested on this report. The reason this information is collected is to ensure accurate and timely payment of medical services to the provider. Collection of information is voluntary.				OMB No. 1215-0137 Expires: 01-31-02																																								
<b>I. Are you applying for a new enrollment or updating your record with our program?</b>																																												
New Enrollment <input checked="" type="checkbox"/>	If updating your record, please enter your Provider Number here: <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span>																																											
Update Request <input type="checkbox"/>	and complete the appropriate sections only																																											
<b>II. Check the provider type below that most closely describes the medical service(s) you provide.</b>																																												
<b>Provider Type</b> (1) <input type="checkbox"/> Physician, Private Practice (2) <input checked="" type="checkbox"/> Physician Corporation or Group Practice (3) <input type="checkbox"/> Hospital (4) <input type="checkbox"/> Durable Medical Equipment Supplier (5) <input type="checkbox"/> Pharmacy	<b>Provider Type</b> (6) <input type="checkbox"/> Pulmonary Rehabilitation (7) <input type="checkbox"/> Skilled Nursing Facility, Nursing Home, Hospice or Home Health Agency (8) <input type="checkbox"/> Ambulance, Other Please Explain Other: _____																																											
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Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>																																												
<b>IV. Please complete one of the following three boxes (A, B or C).</b>																																												
<b>A. Physician Provider (Private Practice)</b>																																												
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">Name: First</td> <td style="width: 20%;">M.I.</td> <td style="width: 20%;">Last</td> <td style="width: 10%;">M.D.</td> <td style="width: 10%;">D.O.</td> </tr> <tr> <td colspan="2">Tax ID Number</td> <td colspan="3">Specialty</td> </tr> <tr> <td colspan="2">Board Certified Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td colspan="3"></td> </tr> <tr> <td colspan="2">Social Security Number</td> <td>License Number</td> <td colspan="2">License Expiration Date</td> </tr> </table>					Name: First	M.I.	Last	M.D.	D.O.	Tax ID Number		Specialty			Board Certified Yes <input type="checkbox"/> No <input type="checkbox"/>					Social Security Number		License Number	License Expiration Date																					
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<b>B. Physician Provider (Corporation or Group Practice)</b>																																												
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<b>C. Non-Physician Provider (Hospital, Durable Medical Equipment Supplier, Pharmacy, Pulmonary Rehabilitation Clinic, Skilled Nursing Facility, Nursing Home Facility, Home Health Agency, Ambulance, Other)</b>																																												
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Official name of your Facility or Agency</td> <td style="width: 50%;">Billing name as it will appear on your bill</td> </tr> <tr> <td>Tax ID Number</td> <td>Medical service you provide</td> </tr> <tr> <td>License Number</td> <td>License Expiration Date</td> </tr> </table>					Official name of your Facility or Agency	Billing name as it will appear on your bill	Tax ID Number	Medical service you provide	License Number	License Expiration Date																																		
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Tax ID Number	Medical service you provide																																											
License Number	License Expiration Date																																											
<b>ALL PROVIDERS MUST COMPLETE THE REVERSE SIDE.</b>																																												
Form OWCP-1158 Rev. Aug 2001																																												

**Figure 4 - Provider Enrollment Form (Front)**





V.

A. Local address and telephone number

Street Number and Name <b>123 Kent Drive</b>		
City <b>Capital Heights</b>	State <b>Maryland</b>	Zip Code <b>20740</b>
Area Code <b>301</b>	Number <b>754-9658</b>	

B. Billing or mailing address - indicate "same" if identical to A. (This is where your checks and remittance reports will be sent.)

Street Number and Name <b>P.O. Box 857</b>		
City <b>Capital Heights</b>	State <b>Maryland</b>	Zip Code <b>20741</b>

VI. NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal laws.

Signature (Provider or Representative and Title) <i>Janet Smith, R.N.</i>	Date <b>02/20/02</b>
--	-------------------------

Please return this completed form to the appropriate program at the following address to prevent a delay in the processing of your bills. To be enrolled/updated in both the Black Lung and Energy Employees Programs, SEPARATE forms must be submitted to each program.

Federal Black Lung Program  
P.O. Box 828  
Lanham - Seabrook, Maryland 20703 - 0828

If you have any questions regarding the completion of the form, please call  
Toll Free: 1-800-638-7072

Energy Employees Occupational Illness Compensation Program  
P.O. Box 727  
Lanham - Seabrook, Maryland 20703 - 0727

If you have any questions regarding the completion of the form, please call  
Toll Free: 1-866-272-2682

Privacy Act Statement

The following information is provided in accordance with the Privacy Act of 1974 and as amended (5 U.S.C.552a). (1) Collection of this information is authorized by the Black Lung Benefits Act (30 U.S.C. 901-945) and the Energy Employees Occupational Illness Compensation Program Act (P.L. 106-398 - EEOICPA). (2) The information in this form will be used to ensure accurate medical provider information for payment of medical bills. Disclosure of your social security number and completion of this form is voluntary; however, failure to provide this information may result in bill payment delays. (3) This information may be furnished to data processing contractors, to the Department of Labor and to the IRS in accordance with the law. (4) Furnishing all requested information will facilitate accurate and timely payment of medical services to the provider.

NOTICE: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

Public Burden Statement

We estimate that it will take an average of 7 minutes to complete this information collection, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this survey, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Room C3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE

Figure 5 - Provider Enrollment Form (Back)

## Direct Deposit of Medical Payments

The Energy Employees Occupational Illness Compensation Program (EEOICP) offers an expedited method for providers to receive their medical payments from the Energy Disability Fund. This initiative, which the U.S. Treasury Management Service calls "Vendor Express" or "Direct Deposit," allows providers to have EEOICP medical payments automatically deposited into their checking or savings accounts by electronic funds transfer (EFT). This procedure is similar to that currently in use by the Medicare program.

This "Vendor Express" service has a significant impact on providers' business dealings with the Federal Government. The electronic system provides vendors with "good" (immediately available) funds on the payment date. Additionally, making payments through the electronic system eliminates the problems associated with lost or stolen checks. The automation of provider payments increases control over the timing of government payments for cash management purposes and also increases payment security.

To obtain payment through the Vendor Express service, providers should take the following steps to enroll and ensure a timely conversion of payments:

- Request a Payment Information Form (Form TSF 3881) by calling the Energy Employees Occupational Illness Compensation Program's toll-free number at:

1-866-272-2682

Or put the request in writing to:

U.S. Department of Labor  
Employment Standards Administration  
Energy Employees Occupational Illness Compensation Program  
P.O. Box 727  
Lanham-Seabrook, MD 20703-0727

- After obtaining the form, complete the provider information in the designated area of Form TSF 3881.
- Discuss payment identification needs with the Automated Clearing House (ACH) at the financial institution involved. All information in the designated section of the form *must* be completed by the financial institution. (Further information is on the back of Form TSF 3881.)
- Return the completed Payment Information Form (TSF 3881) to the following address:

Energy Employees Occupational Illness Compensation Program  
P.O. Box 727  
Lanham-Seabrook, MD 20703-0727

If there are any questions regarding enrolling in the Direct Deposit service, call the EEOICP's toll-free number:

1-866-272-2682

## Payment Information Form Automatic Clearing House (ACH) Vendor Payment System

This form is used for ACH payments with an addendum record that carries payment-related information. Recipients of these payments should bring this information to the attention of their financial institution when presenting this form for completion.

### Instructions For Completing SF 3881 Payment Information Enrollment Form

#### Objective



After completing this section you should be able to accomplish the following:

- Fill out the Payment Information Form ACH Vendor Payment System

**Note: Required fields are shaded.**

#### Medical Provider Information

Field Name	Field Description	Instructions or Comments
	<b>EEOICP Provider #</b>	<b>Print or type Provider Number.</b>
	<b>Name</b>	<b>Print or type Name of the Company, individual, or Institution that will receive the funds.</b>
	<b>Address</b>	<b>The name and address should correspond to the name and address as it appears on the agreement, contract, claim or award document.</b>
	<b>Contact Person</b>	<b>The company contact person.</b>
	<b>Telephone Number</b>	<b>The telephone number of the contact person.</b>

#### Financial Institution Information

Field Name	Field Description	Instructions or Comments
	<b>Name</b>	<b>Type or print name of the Financial Institution.</b>
	<b>Address</b>	<b>Type or print address of the Financial Institution.</b>
	<b>ACH Coordinator Name</b>	<b>Type or print name of the ACH Coordinator and phone number.</b>
	<b>Nine-Digit Routing Transit Number</b>	<b>Type or print routing number.</b>
	<b>Depositor Account Title</b>	<b>Type or print Depositor's Account Title.</b>
	<b>Depositor Account Number</b>	<b>Type or print account number.</b>
	<b>Type of Account</b>	<b>Check the appropriate account type: Checking Savings</b>
	<b>Signature and Title of Representative</b>	<b>The Representative must sign the form and type or print their title.</b>
	<b>Telephone Number</b>	<b>Type or print phone number of the Institution.</b>

## PAYMENT INFORMATION FORM ACH VENDOR PAYMENT SYSTEM

This form is used for ACH payments with an addendum record that carries payment-related information. Recipients of these payments should bring this information to the attention of their financial institution when presenting this form for completion.

### PAPERWORK REDUCTION ACT STATEMENT

The information being collected on this form is required under the provision of 31 U.S.C. 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data by electronic means to vendor's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearing House Payment System.

### MEDICAL PROVIDER INFORMATION

**EEOICP Provider #** \_\_\_\_\_

Name: **Federal Physicians Group**

Address: **123 Kent Drive**  
**Capital Heights, Maryland 20740**

Contact Person Name: **Janet Brown** Telephone Number: **( 301 ) 754-9658**

### AGENCY INFORMATION

Name: **U. S. Department of Labor, Energy Employee Occupational Illness Compensation Program**

Address: **P. O. Box 727**  
**Lanham-Seabrook, MD 20703-0727**

Contact Person Name: \_\_\_\_\_ Telephone Number: **1 ( 866 ) 272-2682 — Toll Free**

### FINANCIAL INSTITUTION INFORMATION

Name: **Federal National Bank**

Address: **1452 North Main Street**  
**Capital Heights, Maryland 20453**

ACH Coordinator Name: **Susan Huntington** Telephone Number: **( 301 ) 754-6548**

Nine-Digit Routing Transit Number: **2 0 5 9 8 7 6 7 1**

Depositor Account Title: **Federal Physicians Group**

Depositor Account Number: **1234567890**

Type of Account: ☒ Checking ☐ Savings

Signature and Title of Representative: **Susan Huntington** Telephone Number: **( 301 ) 754-6559**

SF FORM 3881

DEPARTMENT OF THE TREASURY  
FINANCIAL MANAGEMENT SERVICE

Figure 6 - Payment Information Form, TSF 3881(Front)

**INSTRUCTIONS FOR COMPLETING SF 3881 PAYMENT INFORMATION  
ENROLLMENT FORM**

**Company information (to be completed by the Medical Provider)**

Print or type the Provider Number: the name of the company, individual, or institution that will receive the funds. (The name and address should correspond to the name and address as it appears on the agreement, contract, claim or award document, etc.) The company contact person and telephone number are also to be provided.

**Agency Information (to be completed by the Federal Agency)**

Type or print the name and address of the federal agency making the payment as well as the name to the agency contact person with telephone number.

**Financial Institution Information (to be completed by the FI)**

Type or print the name and address of the FI and the name of the FI ACH/Direct Deposit Coordinator with telephone number.

Type or print the Nine-Digit Routing Transit Number (RTN). If the FI uses a processor, the RTN of the FI should be used. The importance of the correctness of the RTN cannot be overemphasized.

The name of the corporate customer is placed in the block entitled Depositor Account Title.

Type or print the number of the account into which funds are to be deposited. If the FI does not use account numbers up to seventeen (17) characters of the depositor's name or other identification may be entered in this block. Dashes are acceptable as part of the number, but spaces and other characters are not acceptable. The depositor account number must be formatted EXACTLY as it appears in the FI's records.

In some cases, FIs act as agents for the Government and the accounts are not checking or savings accounts. In these instances, the account should be a **trust, general ledger, or reserve account**. When this is the case, the FI should be given explicit instructions to always use "checking" account or "savings" account and that a unique prefix or alpha character should be included in the depositor account number to immediately identify the payment.

Check type of account "Checking" or "Savings."

The FI's representative signs the form and provides a telephone number for contact purposes.

**MEDICAL PROVIDER MAIL FORM TO:**

Energy Employee Occupational Illness Compensation Program  
P.O. Box 727  
Lanham-Seabrook, MD 20703-0727  
1-866-272-2682

**Figure 7 - Payment Information Form, TSF 3881(Back)**

## Provider Enrollment Letter For Hospitals

Dear Provider,

Welcome to the Energy Employees Occupational Illness Compensation Program (EEOICP).

The EEOICP has assigned to your facility a six-digit provider number for billing the program. Your provider number is **123456**. This number must be indicated in block 51 for processing. If the assigned provider number is not indicated on the bill, it will be returned.

All hospitals must submit services (inpatient, outpatient, outpatient diagnostic, and hospice) on a UB-92 summary bill form.

Inpatient stay requires admission/discharge summary, itemization of charges and the beneficiary's accepted/covered ICD-9 billing code.

Outpatient ER services require an emergency room report, an itemization of charges, and the beneficiary's accepted/covered ICD-9 billing code.

Stays including use of an observation room require doctors/nurses progress notes and itemization of charges. Observation room stay is limited to less than 24 hours.

Ambulatory outpatient services require an operative report and physicians and nurses notes.

All payments will be electronically deposited to the financial institution on file.

If you have any questions, please call toll free 1-866-272-2682, Monday through Friday, 8:15 A.M. to 4:45 P.M., Eastern Time.

Sincerely,

Provider Enrollment Specialist  
Energy Employees Occupational Illness Compensation Program  
Medical Bill Operations Department

## **Provider Enrollment Letter For Physicians**

Dear Provider,

Welcome to the Energy Employees Occupational Illness Compensation Program (EEOICP).

The EEOICP has assigned to your facility a six-digit provider number for billing the program. Your provider number is **956789**. This number must be indicated in block 33 for processing. If the assigned provider number is not indicated on the bill, it will be returned.

Medical facilities, such as physicians, physician groups/corporations, ambulance, laboratories, radiology groups, durable medical providers, skilled nursing, etc., must complete the HCFA-1500 billing form using the standard CPT-4/HCPCs and the beneficiary's accepted/covered ICD-9 billing code.

Consultations and pathology services require applicable reports for each date of service.

When billing for durable medical equipment and oxygen, the physician's prescription with the patient's name, diagnosis, equipment request, date and physician's signature is required with each billing.

All payments will be electronically deposited to the financial institution on file.

If you have any questions, please call toll free 1-866-272-2682, Monday through Friday, 8:15 A.M. to 4:45 P.M., Eastern Time.

Sincerely,

Provider Enrollment Specialist  
Energy Employees Occupational Illness Compensation Program  
Medical Bill Operations Department

## **Provider Enrollment Letter For Pharmacies**

Dear Provider,

Welcome to the Energy Employees Occupational Illness Compensation Program (EEOICP).

The EEOICP has assigned to your facility a six-digit provider number for billing the program. Your provider number is **324567**. This number must be indicated in block 7 for processing. If the assigned provider number is not indicated on the bill, it will be returned.

Pharmacies must submit bills on the NCPDP universal billing form.

The bill must indicate the eleven-digit National Drug Code number, metric quantity, and prescription number for each drug billed.

All payments will be electronically deposited to the financial institution on file.

If you have any questions, please call toll free 1-866-272-2682, Monday through Friday, 8:15 A.M. to 4:45 P.M., Eastern Time.

Sincerely,

Provider Enrollment Specialist  
Energy Employees Occupational Illness Compensation Program  
Medical Bill Operations Department

## **Inpatient / Outpatient Hospital Universal Billing Form (UB –92)**

The Energy Employees Occupational Illness Compensation Program (EEOICP) will reimburse for inpatient/outpatient services billed for the patient's accepted condition(s). However, it must be noted that although a claim may be considered payable, certain services will still be excluded from the reimbursable charges, as they may not be directly related to the treatment of the accepted conditions.

Providers must complete the UB-92 Medical Form (shown on the following three pages) for all inpatient/outpatient services and for outpatient emergency room services, ambulatory surgical care, and chemotherapy treatment bills.

The UB–92 is designed to be a summary bill. It provides a summarized one-page account of a patient's stay. Since the EEOICP will reimburse for accepted conditions, it is necessary for the hospital to provide more detailed information than on the UB-92 so that coverage may be determined. All UB-92 billing forms for an inpatient hospital stay must be supplemented by an itemized billing statement and an admission/discharge summary. The itemized statement and admission/discharge summary must be attached to the UB-92.

The following instructions are for the proper completion of the UB-92 form. Several blocks are not required by the EEOICP. These blocks may be completed by providers as necessary. The blocks required are shaded. These blocks are **required** for processing your bills.

Reimbursement for inpatient medical services will be made using condition specific rates based on the Prospective Payment System devised by HCFA (42CFR parts 412, 413, 424, 485 and 489). Using this system, payment is derived by multiplying the diagnosis-related group (DRG) weight assigned to the hospital discharge by the provider specific factors.

### **Skilled Nursing Facility/Nursing Home/Personal Care**

The Energy Employees Occupational Illness Compensation Program (EEOICP) reimburse for all services incurred by the beneficiary while in a nursing home or skilled nursing facility. The services or items, that may be covered, must be submitted on a UB-92 billing form. This includes covered medications and other services such as oxygen and respiratory services.

#### **Personal Care**

Personal Care services such as home health aide, licensed practical nurse or similarly trained individual are covered as a medical benefit, as long as such services are medically necessary. These services must be submitted on a UB-92 billing form. The nurse's plan of care and treatment must be attached to the billing form.

## **Hospice Services**

The Energy Employees Occupational Illness Compensation Program (EEOICP) will reimburse for hospice room and board charges and services rendered for the treatment and care of a beneficiary's accepted condition.

Hospice providers must submit bills to EEOICP on a UB-92 billing form. The plan of cure and treatment must be attached to the UB-92 form and submitted for processing

## UB-92 Inpatient/Outpatient – Hospital Data Elements Instructions

The UB-92 Outpatient Bill must also be supplemented with additional attachments (e.g., ER report and itemized bill, observation notes and itemized bill, surgery/operative report and itemized bill.

Outpatient services such as: X-Ray, Laboratory, EKG, Pathology can be billed on a UB-92 using Revenue Center Codes (RCC) and applicable CPT codes.

### Objective



After completing this section you should be able to accomplish the following:

- Fill out the UB-92 Inpatient medical form.
- Attachments required with the UB-92 Inpatient medical form.

**Note: Required fields are shaded.**

Block #	Block Description	Instructions or Comments
1	Provider Information	Type or print complete provider name. Type or print complete address or post office number. Type or print city, state, and zip code. Type or print area code and telephone number.
2	Blank Field	Type or print Facility Medical Assistance I.D. (MAID) Number
3	Patient Control Number	Type or print Provider's patient account/control number
4	Type of Bill Classification	Type or print appropriate three-digit code. <ul style="list-style-type: none"> <li>• 1<sup>st</sup> position indicates type of facility.</li> <li>• 2<sup>nd</sup> position indicates type of care</li> <li>• 3<sup>rd</sup> position indicates billing sequence</li> </ul>
5	Federal Tax I.D.	Type or print number assigned by the federal government for tax reporting purposes.
6	Covered Days	Type or print dates for the full ranges of services being invoiced. (Period From/Through)
7	COV. D.	Type or print number of Covered Days.
8	N-C D.	Type or print Non Covered Days
9	C-I D.	Type or print Coinsurance Days
10	L-R D.	Type or print Lifetime Reserve Days
11	Blank Field	
12	PATIENT'S NAME	Type or print Last Name, First Name, & Middle Initial. <ul style="list-style-type: none"> <li>• Type or print patient's name as it appears on the Health Plan ID Card.</li> <li>• Use a comma or space to separate the last and first names.</li> <li>• Titles (Mr., Mrs., etc.) should not be reported in this field.</li> <li>• No space should be left after the prefix of a name. Example: McCormick</li> <li>• If the name is hyphenated, both names should be capitalized and separated by a hyphen. Example: Smith-Jones</li> <li>• A space should separate a last name and suffix.</li> </ul>
13	PATIENT'S ADDRESS	Type or print complete mailing address of the patient.
14	BIRTHDATE	Type or print month, year, and day.

Block # contd.	Block Description contd.	Instructions or Comments contd.
15	<b>SEX</b>	<b>Type or print patient's sex (the letter only).</b> <ul style="list-style-type: none"> <li>• M (Male)</li> <li>• F (Female)</li> </ul>
16	MS	Type or print Patient's Marital Status
17	Admission Date	Type or print month, day, and year.
18	HR	Type or print Admission Hour.
19	TYPE	Type or print Admission Type.
20	SRC	Type or print Source of Admission.
21	D HR	Type or print Discharge Hour.
22	<b>STAT</b>	<b>Type or print patient's status on the last day of the billing period.</b>
23	Medical Record Number	Type or print Provider's Medical Record Number.
24 - 30	Condition Codes	Type or print Identify third party resources for payment.
31	Blank Field	Type or print DRG on the lower line.
32 - 35	Occurrence Codes	Type or print Code(s) & Date(s).
36	Occurrence Span Code	Type or print From/Through Date.
37	Blank Field	Resubmissions or adjustments. Type or print the Document Control Number (DCN) of the original claim.
38	<b>Program Payer</b>	<b>Type or print Program Payer</b> <b>U.S. DOL – OWCP - EEOICPA</b>
39 - 41	Value Codes	Type or print Code(s) & Amount(s).
42	<b>REV. CD.</b>	<b>Type or print Revenue Code(s).</b>
43	<b>Description</b>	<b>Type or print Revenue Code Description.</b>
44	<b>HCPCS / RATES</b>	<b>Type or print applicable rate.</b> <b>Rates for private/semi private room.</b> <b>Type or print CPT or HCPCS codes and modifiers based on the Bill Type (Inpatient or Outpatient).</b>
45	SERV. DATE	Type or print Dates of Service for each revenue code or CPT/HCPCS.
46	<b>SERV. Units</b>	<b>Type or print Units of Service.</b>
47	<b>Total Charges</b>	<b>Type or print charges by RCC that when totaled equals amount of 001 RCC.</b>
48	Non-Covered Charges	Type or print Non-Covered Charges.
49	Blank Field	
50	<b>Program Payer</b>	<b>Type or print Program Payer</b> <b>U.S. DOL- OWCP - EEOICPA</b>
51	<b>PROVIDER NO.</b>	<b>Type or print EEOICP Provider ID Number.</b>
52	REL INFO	Release of Information
53	ASG BEN	Entries are Yes (Y) or No (N).
54	<b>Prior Payments</b>	<b>Type or print payments made to the Payer.</b>
55	<b>EST. Amount Due</b>	<b>Type or print estimated amount due (the difference between "Total Charges" and any deductions such as other coverage.</b>
56	<b>Diagnosis-Related Group</b>	<b>Type or print Diagnosis-Related Group (DRG) code.</b>
57	Blank Field	
58	Insured's Name	Type the patient's name. <ul style="list-style-type: none"> <li>• When other coverage is available, the insured is indicated here.</li> </ul>
59	P. REL.	Type the patient's relationship to the insured. Medicaid programs the patient is the insured. <ul style="list-style-type: none"> <li>• Code 01 – Patient is insured.</li> </ul>

Block # contd.	Block Description contd.	Instructions or Comments contd.
<b>60</b>	<b>CERT.-SSN-HIC.-ID NO.</b>	<b>Type or print patient's Social Security number EEOICPA.</b>
61	Group Name	When the patient has other insurance and group coverage applies. Do not use this field for Individual Coverage.
62	Insurance Group No.	When the patient has other insurance and group coverage applies. Do not use this field for Individual Coverage.
63	Treatment Authorization Codes	Type or print Health Plan referral or authorization number.
64	ESC	Employment Status Code <ul style="list-style-type: none"> <li>For each Payer listed in field 50 there must be a corresponding employment status code.</li> </ul>
65	Employer Name	Type or print patient's Employer Name.
66	Employer Location	Type or print Employer's address.
<b>67</b>	<b>PRIN.DIAG. CD.</b>	<b>Type or print complete ICD-9-CM diagnosis code. Enter the 4<sup>th</sup> and 5<sup>th</sup> digits if applicable. Each diagnosis code must be valid for the date of service.</b>
<b>68 - 75</b>	<b>OTHER. DIAG. CODES</b>	<b>Type or print complete ICD-9-CM diagnosis code. Enter the 4<sup>th</sup> and 5<sup>th</sup> digits if applicable. Each diagnosis code must be valid for the date of service.</b>
<b>76</b>	<b>ADM. DIAG. CD.</b>	<b>Admission Diagnosis Code. Type or print complete ICD-9-CM diagnosis code. Type or print the 4<sup>th</sup> and 5<sup>th</sup> digits if applicable. Each diagnosis code must be valid for the date of service.</b>
77	E-Code	Reporting external cause of injury.
78	Blank Field	
79	P.C.	Procedure Code Type: HCPCS, CPT or Revenue <ul style="list-style-type: none"> <li>Used for admissions.</li> </ul>
<b>80 – 81</b>	<b>PRINCIPAL PROCEDURE</b>	<b>Type or print procedure via ICD-9CM &amp; date of occurrence during hospitalization.</b> <ul style="list-style-type: none"> <li><b>Inpatient claims and all surgical procedures require ICD-9-CM codes.</b></li> <li><b>Outpatient claims require CPT/HCPCS codes.</b></li> </ul>
82	Attending Phys. ID	Type or print Physician who has primary responsibility for the patient's medical care or treatment.
83	Other Phys. ID	Type or print Physician who has some responsibility for the patient's medical care or treatment.
84	Remarks	
<b>85</b>	<b>Provider Representative</b>	<b>Signature block. Attests to conformance w/certifications on back of the form.</b>
<b>86</b>	<b>Date</b>	<b>Date bill is submitted.</b>





### Admission Hour Codes

The following chart shows the two-digit codes that are used to designate the hour in which the patient was admitted for inpatient or outpatient care.

Code	Time
00	12: 00 – 12:59 A.M.
01	1:00 – 1:59 A.M.
02	2:00 – 2:59 A.M.
03	3:00 – 3:59 A.M.
04	4:00 – 4:59 A.M.
05	5:00 – 5:59 A.M.
06	6:00 – 6:59 A.M.
07	7:00 – 7:59 A.M.
08	8:00 – 8:59 A.M.
09	9:00 – 9:59 A.M.
10	10:00 – 10:59 A.M.
11	11:00 – 11:59 A.M.
12	12:00 – 12:59 P.M.
13	1:00 – 1:59 P.M.
14	2:00 – 2:59 P.M.
15	3:00 – 3:59 P.M.
16	4:00 – 4:59 P.M.
17	5:00 – 5:59 P.M.
18	6:00 – 6:59 P.M.
19	7:00 – 7:59 P.M.
20	8:00 – 8:59 P.M.
21	9:00 – 9:59 P.M.
22	10:00 – 10:59 P.M.
23	11:00 – 11:59 P.M.

## Scenarios for UB-92 Inpatient Forms

**Directions: Enter the needed information on a UB-92 form. Do not enter information that is not needed. You will be given more information than needed on the form. Answers found on pages 86 and 87.**

### Scenario #1

Patient #1 is Terry Kittle (859-58-6324). He was born on 07/10/16 in Cleveland, OH. He lives on 5487 Plainview Street, Cleveland, OH 45711. He was admitted to the Westside Medical Center. He was hospitalized and had a surgical procedure. His status is 01.

His doctor is Tabitha Jones. She works at Westside Medical Center (Provider # 365874 and Federal Tax I.D. # 65874-3258) located at 1345 North Street, Marietta, OH 45750. The phone number to Westside Medical Center is 302-890-1679.

They submit a claim form that covers procedures from 06/22/01 – 06/27/01 to the U.S. Dept. Of Labor – OWCP - EEOICP.

The bills consist of the following information:

Rev. CD. 206 ICU/Intermediate, 3 days at a rate of \$913.00. Total of \$2739.00;  
Rev. CD. 251 Drugs / Generic. Total of \$1088.90;  
Rev. CD. 270 Med Surgical Supplies. Total of \$503.01;  
Rev. CD. 300 Laboratory, 7 units and a total of \$70.48;  
Rev. CD. 301 Lab/Chem, 23 units and a total of \$862.00;  
Rev. CD. 305 Lab/Hematology, 4 units and a total of \$82.00;  
Rev. CD. 306 Lab/Bact-Micro, 3 units and a total of \$140.00;  
Rev. CD. 320 DX X-Ray, 1 unit and a total of \$110.50;  
Rev. CD. 324 DX X-Ray / Chest, 2 units and a total of \$237.00;  
Rev. CD. 351 CT Scan / Head, 1 unit and a total of \$689.00;  
Rev. CD. 369 OR / Other, 1 unit and a total of \$39.00;  
Rev. CD. 450 Emerg. Room, 2 units and a total of \$593.00;  
Rev. CD. 730 EKG / ECG, 2 units and a total of \$100.00;  
Rev. CD. 761 Treatment RM. Total of \$ 366.00;  
Rev. CD. 981 PRO FEE / ER, 1 unit and a total of \$192.00;  
RCC 001 Total of 50 units and charges of \$7,811.39.

Terry has Inpatient Care and Treatment for 508.1 (Chr Pul Many D/T Radiation), 414.8 (Other specified forms of chronic ischemic heart disease), 294.8 (Other specified organic brain syndromes (chronic)), 311 (Depressive disorder, not elsewhere classified), V10.46 (Prostate), 250.0 (Diabetes mellitus without mention of complication), and 826.0 (Fracture of one or more phalanges of foot –Closed).

Terry had one procedure done on 05/20/01:

89.65 Measurement of systemic arterial blood gases.

**Complete the UB-92 Claim form and submit it to US Dept of Labor – OWCP - EEOICP for payment.**

## **Scenario #2**

Patient #2 is Bruce Carson (698-85-1563). He was born on 12/10/01 in Elmo, UT. He lives on 98 North Main Ave., Elmo, UT 84521. He was admitted to the Kentville Hospital. He had an outpatient surgical procedure. His status is 01.

His Doctor is Sonny Henry. He works at Kentville Hospital (Provider # 365874 and Federal Tax I.D. #62478-6985) located at 6985 South Street, Price, UT 84501. They submitted a claim form that covers procedures from 12/10/01 – 12/10/01 to the U.S. Dept. Of Labor – OWCP - EEOICP.

The bills consist of the following information:

Rev. CD. 250 Pharmacy, 1 unit and a total of \$21.96;  
Rev. CD. 270 Medical Surgical Supplies, 3 units and a total of \$62.40;  
Rev. CD. 410 Respiratory SVC, HCPC (94664), 1 unit and a total of \$26.20;  
Rev. CD. 450 Emerg Room, HCPC (9928325), 1 unit and a total of \$125.00;  
Rev. CD. 730 EKG / ECG, HCPC (93005), 1 unit and a total of \$75.00;  
Rev. CD. 985 Pro Fee / EKG (93010), 1 unit and a total of \$35.00;  
Rev. CD. 001 Total Charges \$345.96.

He had Outpatient Care and Treatment for:

1) 491.21 - Chronic bronchitis without acute exacerbation.

Complete the UB-92 Claim form and submit it to US Dept of Labor – OWCP - EEOICP for payment.

## **HCFA-1500 Physician Services**

The Energy Employees Occupational Illness Compensation Program (EEOICP) will reimburse for physician services rendered in the treatment of a beneficiary's accepted condition. Services are reimbursable under the following categories: Office visits, hospital visits, procedures at an outpatient clinic, home visits, consultations, hospice services, immunizations for flu and pneumonia, radiology for the diagnosis and/or treatment of accepted condition, prescriptions, and administration of drugs for the covered condition(s).

## **Specialized Services Information**

Durable Medical Equipment and Supplies and Home Nursing visits for the accepted condition(s) may be reimbursed if the provider submits a completed HCFA-1500 billing form with the physician prescription and justification for the specialized service attached to the bill.

Note: The above process must be done each time that the services are rendered and the bill is submitted for processing.

When care is rendered for an acute condition causing hospitalization, emergency room, or ambulatory care services, the acute condition must be indicated on the billing form before reimbursement can be considered.

The following is an explanation of the proper completion of the HCFA-1500 form. Several blocks are not required under the EEOICP. These blocks may be completed by the provider as necessary. The blocks that are required by the EEOICP are shaded. These blocks are required for processing your bills under the EEOICP.

## **Chiropractic Services**

Services of a chiropractor may be reimbursed and limited to treatment to correct a spinal subluxation. Physical and related laboratory tests performed by or required by a chiropractor to diagnose a spinal subluxation are payable.

A diagnosis of spinal subluxation demonstrated by x-ray to exist must appear in the chiropractor's report before payment of services can be considered.

A chiropractor may interpret his or her x-rays to the same extent as any other physician.

## **Clinical Psychologists**

A clinical psychologist may serve as a physician within the scope of his or her practice. Testing, evaluation, and other services under the direction of a qualified physician may be performed by a clinical psychologist.

## **HCFA-1500 Ambulance Services**

Ambulance providers must complete the HCFA-1500 billing form (Figure 9) for all ambulance services. Providers must be enrolled in the Energy Employees Occupational Illness Compensation Program (EEOICP) before costs for their services will be reimbursed under this program. Providers must put their six-digit DOL provider number in Block 33 of the HCFA-1500. EEOICP treatment bills should be mailed to:

Energy Employees Occupational Illness Compensation Program  
P. O. Box 727  
Lanham-Seabrook, MD 20703-0727

Ambulance providers must bill the program using the HCFA Common Procedure Coding System. The Ambulance Codes are included in this manual. The fee billed should be an all-inclusive charge for one-way transport.

The following is an explanation of the proper completion of the HCFA-1500 form for ambulance services. Several blocks are not required under the EEOICP. These blocks may be completed by the provider as necessary. The required blocks are shaded in the following instructions. These blocks are required for processing your bills. A sample HCFA-1500 form appears in Figure 9 - HCFA 1500 Form.

## **Ambulance Services**

Ambulance service (basic and life support) is reimbursable when required for a beneficiary's accepted covered condition(s). Transportation in an ambulance is covered for the following transports:

- Home to hospital
- Hospital to another hospital
- Hospital to a skilled nursing facility or chronic care institution
- Physician's office to hospital

Reimbursement for transportation by air ambulance and from hospital to home will only be approved if medical documentation is attached to the bill.

Documentation for air ambulance must include: Physician's rationale for necessity of air travel, severity of condition, and miles traveled.

Documentation must be either the hospital discharge summary detailing the patient's condition (i.e., use of volume ventilator or continuous oxygen therapy) or a physician's statement indicating the need for this transport at the time of discharge.

## **Ambulance Codes**

### **Ambulance Place of Service Codes**

- \*\*AA—Ambulance trip by air ambulance
- EH—Ambulance trip from SNF or NH to hospital
- HE—Ambulance trip from hospital to SNF or NH
- HH—Ambulance trip for discharge/transfer from one hospital to another
- \*HR—Ambulance trip from hospital to patient's residence
- HT—Ambulance trip from one hospital to another
- PH—Ambulance trip from physician's office to a hospital
- RH—Ambulance trip from patient's residence to a hospital

### **Ambulance HCFA Common Procedure Codes**

A0302—Ambulance service, basic life support (BLS) base rate, all-inclusive services, emergency transport, one-way

A0310—Ambulance service, advanced life support (ALS) base rates, all-inclusive services, emergency transport, one-way

\*\*Requires documentation from the treating physician supporting the reason an air ambulance trip was necessary to transport the patient and must be attached to the bill and sent to the DOL/DEEOIC in Lanham, MD.

\*Requires documentation from the treating physician supporting the reason an ambulance was required to transport patient from hospital to home and must be attached to the bill and sent to the DOL/DEEOIC in Lanham, MD.

## **Pulmonary Rehabilitation Providers**

### **Facility Approval**

To participate in the Energy Employees Occupational Illness Compensation Program (EEOICP), all Pulmonary Rehabilitation Facilities must have prior approval from the Department of Labor. The guidelines for approval are based on review of the Pulmonary Rehabilitation Facilities Program content, leveling criteria, and staffing responsibilities.

#### **Send correspondence to:**

**Department of Labor  
Office of Workers Compensation  
Branch of Medical Standards and Rehabilitation (BMSR)  
200 Constitution Avenue, N.W.  
Washington, D.C. 20210  
Attn: Pat Wood, R.N.**

## HCFA-1500 – Physician Treatment – Provider Submitted Instructions

The HCFA-1500 claim form must be completed for all professional medical services.

### Objective



After completing this section you should be able to accomplish the following:

- Fill out the HCFA-1500 medical form.
- Attachments required with the HCFA-1500 medical form.
- Consequence for not completing the HCFA-1500 medical form correctly.

**Note: Required fields are shaded.**

Block #	Block Description	Instructions or Comments
1	Insurance Program Identification	Check the health coverage. This field indicates the payer to whom the claim is being filed.
<b>1a</b>	<b>Insured's I.D. Number</b>	<b>Type or print patient's I.D. Number</b>
<b>2</b>	<b>Patient's Name</b>	<b>Type or print patient's last name, first name and middle initial.</b>
3	Patient's Birth Date & Sex	Type or print MM/DD/YY and Male (M)/Female (F).
4	Insured's Name	Type or print patient's name as it appears on the member's Health Plan I.D. card.
<b>5</b>	<b>Patient's Address</b>	<b>Type or print patient's complete address and telephone number.</b>
6	Patient Relationship to Insured	Enter Self.
7	Insured's Address	Type or print patient's complete address and telephone.
8	Patient's Status	Type or print patient's marital status.
9	Other Insured's Name	Refers to someone else, if the patient is covered by another insurance plan.
9a	Other Insured's Policy or Group Number	Refers to someone else, if the patient is covered by another insurance plan.
9b	Other Insured's Birth Date / Sex	Type or print Birth Date (mm/dd/yy) and Sex (M) or (F).
9c	Employer's Name or School Name	Type or print Employer's name or the School name if the insured is in school.
9d	Insurance Plan Name or Program Name	Type or print name of the Insured's Insurance Plan or Program name.
10a – 10c	Is Patient's Condition Related To	Answer each category with a Yes or No.
10d	Reserved For Local Use	
<b>11</b>	<b>Insured's I.D. Number</b>	<b>Type or print Patient's I.D. Number Social Security Number</b>
11a	Insured's Policy Group or FECA Number	Type or print other insurance that is available.
11b	Employer's Name or School Name	Type or print Insured's Employer Name or school name if applicable.
11c	Insurance Plan Name or Program Name	Type or print name of the Health Plan.
11d	Is There Another Health Benefit Plan?	Enter a checkmark in the Yes or No box.

<b>Block # contd.</b>	<b>Block Description contd.</b>	<b>Instructions or Comments contd.</b>
<b>12</b>	<b>Patient's or Authorized Person's Signature</b>	<b>Valid Signatures</b>
<b>13</b>	<b>Insured's or Authorized Person's Signature</b>	<b>Signature Substitutes</b>
14	Date of Current Illness (First symptom) or Injury (Accident) or Pregnancy (LMP)	Type or print mm/dd/yy.
15	If Patient Has Same or Similar Illness. Give First Date.	Type or print mm/dd/yy.
16	Dates Patient Unable to Work In Current Occupation.	Type or print mm/dd/yy.
17	Name of Referring Physician or Other Source	Provider other than the member's primary care physician rendered invoiced services.
18	Hospitalization Dates Related To Current Occupation	When place of service is inpatient, enter the mm/dd/yy.
19	Reserved For Local Use	Type or print Individual Provider's Medical Assistance I.D. (MAID) number.
20	Outside Lab / Charges	Enter Yes or No. If Yes, enter the amount.
<b>21</b>	<b>Diagnosis or Nature of Illness or Injury</b>	<b>Type or print diagnosis codes must be valid ICD-9 codes for the date of service.</b> <ul style="list-style-type: none"> <li><b>E codes are not acceptable as a primary diagnosis.</b></li> </ul>
22	Medicaid Resubmission	For re-submissions or adjustments, enter the Document Control Number) of the original claim.
23	Prior Authorization Number	Type or print referral or authorization number. <ul style="list-style-type: none"> <li>Refer to Provider or Hospital Manual to determine if services rendered require an authorization or referral.</li> </ul>
<b>24a</b>	<b>Dates of Service</b>	<b>From date and To date. If the same day, type or print From and To date as the same date. (mm/dd/yy)</b>
<b>24b</b>	<b>Place of Service</b>	<b>Type or print HCFA standard place of service code.</b>
<b>24c</b>	<b>Type of Service</b>	<b>Type or print Service code represents the service rendered.</b> <ul style="list-style-type: none"> <li><b>Refer to the billing manual for valid entries.</b></li> </ul>
<b>24d</b>	<b>Procedure Code(s)</b>	<b>Type or print 5-digit Procedure code.</b> <ul style="list-style-type: none"> <li><b>The procedure code must be valid for the date of service.</b></li> </ul>
<b>24e</b>	<b>Diagnosis Code(s)</b>	<b>Type or print diagnosis Pointer indicates the associated diagnosis by referencing the pointers in field 21.</b>
<b>24f</b>	<b>Charges for Service</b>	<b>Type or print charges.</b>
<b>24g</b>	<b>Days or Units</b>	<b>Type or print quantity.</b> <ul style="list-style-type: none"> <li><b>Use 2 characters.</b></li> </ul>
24h	EPSDT Family Plan	
24i	EMG	

<b>Block # contd.</b>	<b>Block Description contd.</b>	<b>Instructions or Comments contd.</b>
24j	COB	
24k	Reserved For Local Use	
<b>25</b>	<b>Federal Tax I.D. Number</b> <ul style="list-style-type: none"> <li>• SSN – Not needed</li> <li>• EIN – Not needed</li> </ul>	<b>Type or print Physician's or Supplier's Federal Tax I.D. number.</b>
26	Patient's Account No.	The Provider's billing account number.
27	Accept Assignment	Enter Yes or No.
<b>28</b>	<b>Total Charge</b>	<b>Type or print Sum of all charges under 24F.</b>
29	Amount Paid	Type or print payment received from another payer.
30	Balance Due	Type or print amount due.
<b>31</b>	<b>Signature / Date of Physician or Supplier</b>	<b>The Physician's signature and date must be entered in this field.</b>
<b>32</b>	<b>Name / Address of Facility where services where rendered (if other than home or office)</b>	<b>Type or print physical location.</b> <ul style="list-style-type: none"> <li>• P.O. Box Numbers, not allowed.</li> </ul>
<b>33</b>	<b>Physician's, Supplier's Billing Name, Address, Zip Code, Phone Number, and Provider Number</b>	<b>Type or print complete name and address of the provider.</b> <b>Type or print Provider's Number EEOICP Provider Number.</b>



HEALTH INSURANCE CLAIM FORM											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA (BLR LUM) (SSN) <input type="checkbox"/> OTHER 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM) <b>123-45-6789</b>											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Jones, Kevin</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>M</b> <b>SEX</b> <b>F</b>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No. Street) <b>12589 Foxwood Drive</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED ADDRESS (No. Street)		
CITY <b>Cleveland,</b>			STATE <b>OH</b>			CITY			STATE		
ZIP CODE <b>69852</b>			TELEPHONE (Include Area Code) <b>(204) 368 - 4906</b>			ZIP CODE			TELEPHONE (Include Area Code)		
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						9. PATIENT'S STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			10. IS PATIENT'S CONDITION RELATED TO:		
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/>			11. INSURED'S POLICY OR FECA NUMBER <b>123-45-6789</b>		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY <b>M</b> <b>SEX</b> <b>F</b>						b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			a. INSURED'S DATE OF BIRTH MM DD YY <b>M</b> <b>SEX</b> <b>F</b>		
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME						10a. RESERVED FOR LOCAL USE			c. INSURANCE PLAN NAME OR PROGRAM NAME		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED <b>Signature on File</b> DATE						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier to services described below.  SIGNED <b>Signature on File</b>					
14. DATE OF CURRENT: MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						17a. I.D. NUMBER OF REFERRING PHYSICIAN			20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGE		
19. RESERVED FOR LOCAL USE						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEM 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. <b>786.50</b>			22. MEDICARE RE submission CODE ORIGINAL REF. NO.		
24. A. DATES OF SERVICE MM DD YY 03 07 01 03 07 01						B. PLACE OF SERVICE 2 3			C. TYPE OF SERVICE 01		
D. PROCEDURES, SERVICES OR SUPPLIES 99285						E. DIAGNOSIS CODE 1			F. CHARGES 308 00		
G. DAYS OF SERVICE 1						H. EPISODE OF CARE 1			I. RESERVED FOR LOCAL USE		
25. FEDERAL TAX I.D. NUMBER 12345-6789						26. PATIENT'S ACCOUNT NUMBER 658712434			27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		
28. TOTAL CHARGE 308 00						29. AMOUNT PAID			30. BALANCE DUE		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS <b>Michelle Jones</b>						32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office) <b>Eastern Medical Center 1802 Main Street Cleveland, OH 36632</b>			33. PHYSICIAN, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE <b>Eastern Medical Center 1802 Main Street Cleveland, OH 36632 (204) 368-5602 Provider # 100100</b>		
SIGNED DATE						DATE			DATE		

Figure 9 - HCFA 1500 Form

### Place of Service (POS) Codes

Code	Description
11	Physician's Office
12	Patient's Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room-Hospital
24	Ambulatory Surgical Center
26	Military Treatment Facility
31	Skilled Nursing Facility (SNF)
32	Nursing Facility/Nursing Home (NH)
34	Hospice
41	Ambulance – Land
42	Ambulance – Air and Water
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
N/A	Pharmacy
N/A	Other Med/Surg. Facility (Ambulatory Surgical CTR)
N/A	Radiation Therapy Center
N/A	Home to Hospital
N/A	Home to Med Practitioner/Lab
N/A	(AA) Ambulance Trip by Air Ambulance
N/A	(EH) Ambulance Trip from SN for NH to Hospital
N/A	(EE) Ambulance Trip from Hospital to SNF or NH
N/A	(HH) Ambulance Trip for Discharge/Transfer from one Hospital to Another
N/A	(HR) Ambulance Trip from Hospital to Patient's Residence
N/A	(HT) Ambulance Trip from one Hospital to Another
N/A	Hospital to SNF
N/A	Hospital to Hospital
N/A	Hospital to Other (Home, Med Practitioner/Lab)
N/A	Med Practitioner/Lab to Hospital
N/A	(TH) Ambulance Trip from Physician's Office to a Hospital
N/A	(RH) Ambulance Trip from Patient's Residence to a Hospital
N/A	Med Practitioner/Lab to Other (Home Med Practitioner/Lab)
N/A	Other to Hospital

**Note: A Place of Service (POS) code must be present. This indicates where the service was rendered (optional for pharmacies).**

**Type of Service (TOS) Codes**

<b>Code</b>	<b>Description</b>
<b>1</b>	<b>Medical Care</b>
<b>2</b>	<b>Surgery</b>
<b>3</b>	<b>Consultation</b>
<b>4</b>	<b>Diagnostic x-ray (Full Fee)</b>
<b>P</b>	<b>Diagnostic x-ray (Professional Component)</b>
<b>T</b>	<b>Diagnostic x-ray (Technical Component)</b>
<b>5</b>	<b>Diagnostic Laboratory (Full Fee)</b>
<b>P</b>	<b>Diagnostic Laboratory (Professional Component)</b>
<b>T</b>	<b>Diagnostic Laboratory (Technical Component)</b>
<b>6</b>	<b>Radiation Therapy (Full Fee)</b>
<b>P</b>	<b>Radiation Therapy (Professional Component)</b>
<b>T</b>	<b>Radiation Therapy (Technical Component)</b>
<b>7</b>	<b>Anesthesia</b>
<b>8</b>	<b>Surgery – Assistant</b>
<b>9</b>	<b>Other Medical Service (Ambulance)</b>
<b>A</b>	<b>DME – Rental</b>
<b>B</b>	<b>DME – Purchase</b>
<b>C</b>	<b>Transportation - Travel</b>
<b>F</b>	<b>Ambulatory Surgical Center</b>
<b>G</b>	<b>Lodging</b>
<b>H</b>	<b>Hospice</b>
<b>I</b>	<b>Drugs – Oral DOL Generic</b>
<b>J</b>	<b>Drugs – Injected DOL Generic</b>
<b>N</b>	<b>Nursing – Home</b>
<b>X</b>	<b>Pulmonary Rehabilitation</b>

## Scenarios for HCFA-1500 Forms

**Directions:** Enter the needed information on a HCFA-1500 claim form. Do not enter information that is not needed. You will be given more information than needed on the form. Answers found on pages 88 and 89.

### Scenario #1

Patient #3 is Rodney Williams (658-45-8912). He was born on 02/23/50. Rodney lives on 6987 Greenwich Drive, Richmond, IH 47374. His phone number is (204) 368-4906. He was admitted to the Johnson Memorial Hospital, 1820 Chester Ave., Richmond, IH 35874.

His doctor is Michelle Jones. Her phone number is (204) 368-5602. She works at Johnsons Memorial Hospital (Provider #685487 and Federal Tax I.D. # 68534-1235) located at 1820 Chester Ave., Richmond, IH 35874. They submit a claim form that covers the procedure on 12/17/01 to the U.S. Dept. Of Labor – OWCP - EEOICPA.

The bills consist of the following information:

He has Diagnosis of 200.1 (Other Mal Neo Lymphoid/Histiocytic).

The Place of Service Code is 12 and the Type of Service is T.

He had 4 procedures done at 1 unit, they are the following:

84560 – Uric Acid Urine (\$30.00)

87070 – Cult Bact. Aerobic Any Other Source (\$48.00)

87205 – Smear Primary Source W Interp Rout Stain (\$29.00)

89051 – Cell Count Miscell BOD Fluids W Diff (\$30.00)

Total charge of \$137.00.

**Complete the HCFA-1500 Claim form and submit it to US Dept of Labor – OWCP - EEOICP for payment.**

## **Scenario #2**

Patient #4 is Ginger Graham (123-45-6789). She lives on 123 South Street, Richmond, VA 36632. Her phone number is (652) 968-3214. She was admitted to Northern Medical Center.

Her Doctor is Ben Hanks. He works at Westside Regional Medical Center (Provider #100100 and Federal Tax I.D. # 12345-6789) located at 1802 Main Street, Cleveland, OH 36632. His phone number is (204) 368-5602. They submitted a claim form that covers the procedure on 03/08/01 to the U.S. Dept. Of Labor – OWCP - EEOICP.

The bills consist of the following information:

Diagnoses 153.9 (Malignant Neo Colon).

She had the following procedures:

71010 (Chest X-Ray) done at 1 unit for a total charge of \$35.00. Diagnosis Codes: 1 Type of Service: 4

99211 (Office Visit. EST. PT. Problem Minimal) done at 1 unit for a total charge of \$100.00. Diagnosis Codes: 1 Type of Service: 1

94680 (Oxygen uptake, expired gas analysis; rest and scenarios, direct, simple) done at 1 unit for a total charge of \$50.00. Diagnosis Code: 1 Type of Service: 1

Total Charges of \$185.00.

**Complete the HCFA-1500 Claim form and submit it to US Dept of Labor – OWCP - EEOICP for payment.**

## **NCPDP Universal Pharmacy Billing**

Prescription drugs for the treatment of the beneficiaries accepted condition and related consequential injury conditions are reimbursable. Medications prescribed for unrelated conditions and over-the-counter drugs will not be reimbursed under the program.

Pharmacy providers can bill the Energy Employees Occupational Illness Compensation Program (EEOICP) on the NCPDP Universal Pharmacy Billing Form.

Pharmacy providers must be enrolled in the EEOICP before requesting reimbursement for prescribed medications. The six-digit DOL/EEOICP Provider Number must appear in block 7 on the NCPDP Universal Pharmacy Billing Form.

The following instructions are for the proper completion of the NCPDP Universal Pharmacy Billing Form. Several blocks of the Universal Form are not required by the EEOICP. These blocks may be completed by Providers as necessary. The blocks required are shaded. These blocks are required for processing your bills.

## NCPDP Universal Pharmacy Billing Form

The NCPDP Universal Pharmacy Billing form will be completed for Pharmacy services.

### Objective



After completing this section you should be able to accomplish the following:

- Fill out the NCPDP Universal Pharmacy billing form.
- Where to mail the billing form.
- Attachments required with the billing form.
- Consequence for not completing the billing form correctly.

**Note: Required fields are shaded.**

Field #	Field Description	Instructions & Comments
1	Group No.	Program Payer's Name: Energy Employees Occupational Illness Compensation Program
2	Cardholder I. D. No.	Type or print Cardholder's I. D. • Social Security Number
3	Cardholder Name	Type or print Last Name, First Name, and Middle Initial.
4	Pharmacy Information	Type or print Name of the Pharmacy.
5	Street No.	Type or print street address of the Pharmacy.
6	City, State & Zip	Type or print City, State & Zip Code where the Pharmacy is located.
7	Pharm. No.	Type or print Six-Digit EEOICP Provider Number.
8	Date RX(s) Filled	Type or print date the prescription is filled.
9	Patient's Name	Type or print Last Name, First Name & Middle Initial.
10	Authorized Pharmacy Representative	Valid Signatures, Signature Substitutes and Miner Authorization Substitutes that represent the Pharmacy may sign.
11	RX Number	Type or print Prescription Number.
12	New / Refill	Type or print N(New) or R(Refilled) if the prescription is new or being refilled.
13	Metric Quantity	Type or print total number of units (caps/tabs/ml) dispensed.
14	Days Supply	Type or print total number of days supply.
	National Drug Code	
15	Labeler No.	Type or print labeler number of the Named of Drug.
15a	Product No.	Type or print product number.
16	PKG.	Type or print package number.
17	Prescriber Ident.	Type or print I. D. of the Prescribing MD.
18	Total Price	Type or print total charges of the medication prescribed.



## **Scenarios for NCPDP Universal Pharmacy Billing Forms**

**Directions:** Enter the needed information on a NCPDP Universal Pharmacy Billing form. Do not enter information that is not needed. You will be given more information than needed on the form. Answers found on page 90.

### **Scenarios #1**

Patient #5 is Paul Harris (123-45-6789). His phone number is (786) 463-4322. Paul lives on 123 South Street, Jacksonville, FL 36632. He went to Ben Haver MD on 06/05/01. Doctor Haver gave him a 30 day prescription of Deltasone (Rx # 628568) 5 MG TAB, 60 units plus a refill date of 01/09/03. Labeler # 00009, Product #0045 and 01 package. The prescription I.D. number is AM5535767. The medication cost \$7.50.

His Pharmacy is CVS Pharmacy. The Pharmacy number is 567890. The pharmacy is located at 1802 Main Street, Jacksonville, FL 36632. The phone number is 800-648-2993. They submit a billing form for a total of \$7.50 to the U.S. Dept. Of Labor – OWCP - EEOICP.

**Complete the NCPDP Universal Pharmacy Billing form and submit it to US Dept of Labor – OWCP - EEOICP for payment.**

### **Scenario #2**

Patient #6 is Peter Hart (123-45-6789). His phone number is (764) 345-2981. He lives on 123 South Street, Jacksonville, FL 36632. He went to Ben Haver MD on 11/02/02. Doctor Haver gave him a 30 day prescription of Deltasone (Rx # 628568) 5 MG TAB, 60 units and no refills at a total of \$200.00. Labeler # 00638, Product # 29198 and 01 package. The prescription I.D. number is AM5535767

His Pharmacy is Rite-Aid. The Pharmacy number is 555120. The pharmacy is located at 1802 Main Street, Jacksonville, FL 36632. The phone number is 800-648-2994. They submit a billing form for a total of \$200.00 to the U.S. Dept. Of Labor – OWCP - EEOICP.

**Complete the NCPDP Universal Pharmacy Billing form and submit it to US Dept of Labor – OWCP - EEOICP for payment.**

## **Remittance Advice**

The Remittance Advice Form (RA) supplies bill payment information to providers for services rendered and reimbursed by DOL/EEOICP. The RA is a computer-generated document showing a detailed breakdown of bills approved, denied, or in process. The RA is designed to simplify the provider's accounting by allowing for accurate reconciliation of the RA with submitted bills. The RAs mailed weekly provides payment information to the provider. The RAs are mailed from CSC in Lanham separately from the payments issued by the United States Treasury Department and should be received around the same time as the U.S. Treasury payment. These payments can be matched to the RA by comparing the RA number, which appears on both. A sample RA and a description are included in this section.

## **Approved Bills**

Approved bills that are paid will appear on the RA as paid, with a breakdown of the beneficiary's name, patient's account number (if shown on bill), dates of service, service code, number of days or units, billed amount, and paid amount. An Explanation of Benefits (EOB) message will appear if reimbursement is not made at the billed amount or if payment is reduced. The beneficiary's social security number, internal control number (ICN), and third party payment information are also listed. Bills may be paid as submitted or partially paid, in accordance with program reimbursement policy.

## **Denied Bills**

Denied bills include an EOB message explaining why payment of the bill was denied. The provider should refer to the EOB listing in this manual for further explanation of codes.

If providers have any questions regarding bills submitted to the Program, they should call the toll-free line:

1-866-272-2682

or submit their questions in writing to:

Energy Employees Occupational Illness Compensation Program  
Attn: Correspondence Unit  
P.O. Box 727  
Lanham-Seabrook, MD 20703-0727

All written inquiries concerning such bills should be identified with a six-digit DOL Provider Number and include a copy of the RA and the bill.

## **Bills in Process**

Bills in process are also listed on RAs to let providers know that the bills have been received, but have not yet reached final resolution (approval or denial).

## **Explanation of the RA Form**

The top of each page of the RA reflects the provider's name and address, Provider Number, RA number, date the RA was generated, and page number of the RA. For all bills that have reached final resolution (paid, partially paid, or denied), there will be a corresponding entry on the RA. This entry reflects payment information for every line charge submitted on each bill processed. The sample RA (Figure 12) which follows on the next two pages, contains items noted by circled numbers and descriptions of numbered items.

<b>Block #</b>	<b>Listed below is a block-by-block description of the items reflected on the RA:</b>
1	Beneficiary's Name
2	Patient's Account Number (provider's internal account number, if used)
3	Service Dates (from and through)
4	Service Code (TOS/Procedure Code, RCC, National Drug Code, or HCPC Code)
5	Quantity (days or units)
6	Billed Amount (amount billed by the provider for each service rendered) -Also the bill total
7	Payment Amount (amount of the bill paid by the ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM for each service)
8	EOB MSG (Explanation of Benefits [EOB] Codes) - See Example 24
9	Beneficiary's Social Security Number
10	Internal Control Number (ICN)
11	Payment Other (third-party payments)
12	Total Number of Paid and Denied Bills
13	Total Dollar Amount Billed
14	Total Dollar Amount Denied
15	Total Amount Paid for All Processed Bills

Following the entries for processed bills (approved or denied) is a listing of bills that are presently in process. These bills are listed under the heading **\*\*\*BILLS IN PROCESS\*\*\***. Below is a block-by-block description of the items reflected on the RA for bills in process:

<b>Block #</b>	<b>Listed below is a block-by-block description of the items reflected on the RA:</b>
16	Beneficiary's Name
17	Patient's Account Number (provider's internal account number, if used)
18	Service Dates (from and through)
19	Service Code (TOS/Procedure Code, RCC, NDC, or HCPC, etc.)
20	Quantity (days or units)
21	Billed Amount (the amount billed by the provider for each service rendered)
22	Total Number of Bills in Process
23	Total Billed Amount of All Bills in Process
24	The EOB messages shown in Column 8 correspond with written messages at the end of the RA
25	Net Amount Paid (current and year-to-date amounts paid)



Remittance Advice  
Explanation of Benefits

**U.S. Department of Labor**  
Employment Standards Administration  
Office of Workers' Compensation Programs  
Division of Energy Employees Occupational Illness Compensation



Westside Health Center  
P.O. Box 358  
Paducah, KY 40448

PROVIDER #: 100100  
RA NUMBER: 100110600186  
Date 01/12/02  
PAGE 1

BENEFICIARY NAME	PATIENT ACCOUNT #	SERVICE DATE FROM   THRU	DRUG CODE	QTY	BILLED AMOUNT	PAYMENT AMOUNT	EOB MSG
*****PAID AND DENIED BILLS*****							
WIGGINS	25621	032201	00047083030	0020	11.87	10.68	288
BENEFICIARY SSN: 321-56-9874 ICN: 3698521478596					PAYMENT OTHER:	.00	
JENNINGS	69857	031901	00074632011	0030	15.20	14.79	288
BENEFICIARY SSN: 968-52-5213 ICN: 9685236587451					PAYMENT OTHER:	.00	
WILLIAMS	95247	032001	38130001201	0100	17.55	17.55	
BENEFICIARY SSN: 358-46-7851 ICN: 4557525873241					PAYMENT OTHER:	.00	
FITZGERALD	32541	031501	49502068560	0300	182.41	182.41	
BENEFICIARY SSN: 965-24-1598 ICN: 3255848974256					PAYMENT OTHER:	.00	
ADAMS	98236	032201	25879642158	0060	46.63	46.63	
BENEFICIARY SSN: 452-98-3514 ICN: 8745892354156					PAYMENT OTHER:	.00	
-----							
***** TOTAL PAID/DENIED BILLS:			5	273.66	1.60	272.06	AMT PAID
288	A PORTION OF YOUR REIMBURSEMENT HAS BEEN DENIED BECAUSE THE AMOUNT EXCEEDS THE MAXIMUM ALLOWED DOLLAR AMOUNT.						
NET AMOUNT PAID: CURRENT:			272.06	YEAR TO DATE:		3,694.84	

See Important Message on Back

Form ESI 1175  
Rev. Sept. 2001

Figure 11 - Remittance Advice Form

## IMPORTANT MESSAGE

For additional information, call or print or type the: **U.S. Department of Labor, Employment Standards Administration, Division of Energy Employees Occupational Illness Compensation, P.O. Box 727, Lanham-Seabrook, MD 20703-0727, 1-866-272-2682 (Nationwide).**

For identification, the RA number shown in the front of this remittance advice form appears on your bank transaction for EFT (electronic funds transfer/direct deposit).

The number 3 message below applies only **if the phrase “net amount payable to Dept. Of Labor” appears on the reverse side of this form.**

This is to notify you that the amount identified as “net amount payable to Dept. of Labor” on the “total adjustments” line of the preceding section of this Remittance Advice constitutes an overpayment to you and is to be refunded to the Federal Energy Employees Occupational Illness Compensation Program. You the right to dispute the fact, amount and/or circumstances of the alleged overpayment in accordance with provisions of the Debt Collection Improvement Act of 1996. Unless you have already done so, please refund the total amount of the overpayments identified within 30 days from the date of this notice. **Refund checks are to be made payable to the U.S. Department of Labor, Attention: ADP, Branch Chief, DEEOIC, and mailed to the following address: P.O. Box 77918, Washington, D.C. 20013-7918.** Amounts remaining outstanding 30 days after the date of this notice will be subject to a late charge in the form of interest at the rate established by the U.S. Department of Treasury for late payments owed the Federal Government.

You can initiate an **automated recoupment plan by contacting the Division of Energy Employees Occupational Illness Compensation at 200 Constitution Avenue, N.W., Room C4511 Washington, DC 20210 (Phone 202-693-0192).** After 30 days, if the debt is unpaid and no plan for recoupment was negotiated, DOL will initiate recoupment from current payments, or consider the debt to be delinquent.

## DELINQUENT DEBTS

In regard to the **“net amount payable to the Dept. of Labor”** on the reverse side of this form, this is your notification that the Debt Collection Improvement Act of 1996 requires that unpaid debts to the Federal Government be referred to the U.S. Treasury Department for collection and inclusion in the Treasury Department Offset Program. Under the Offset Program, the Department of Treasury may reduce or withhold any of your eligible Federal payments by the amount of your debt. This process is authorized by the Act. The U.S. Treasury Department is not required to send notice before payments are offset. Federal payments eligible for offset include: income tax refunds; Federal or military pay; contractor/vendor payments; certain federal benefit payments; and other Federal payments, including certain loans that are not exempt from offset.

You may copy our records related to your debt. **If you believe that all or part of the debt is not past due or legally enforceable, you must send evidence to support your position to: U.S. Department of Labor, Division of Energy Employees Occupational Illness Compensation Program, Attention: ADP Branch Chief, P.O. Box 77918, Washington, DC 20013-7918.** If payment or a request for review is not received, the Treasury Department is authorized to disclose delinquent account information to credit bureaus and process your debt for collection to a private collection agency.

**To avoid referral to the Treasury Department Offset Program, you must do one of the following by (60) days from the date of this remittance advice: (1) Repay the debt; (2) Agree to a Repayment Plan.** You are not subject to offset while a bankruptcy stay is in effect. Please notify us of any stay by sending evidence.

Before filing a joint income tax return, contact the IRS to protect any refund payable to your spouse, who is not a delinquent debtor.

**Figure 12 - Back of Remittance Advice Form**

## EOB Descriptions

Codes	Descriptions
001	Revenue Center code is missing. Please complete and resubmit.
004	Our records show Billing Provider ineligible on date of service.
005	Place of service code is missing or invalid for this procedure. Correct and resubmit if appropriate.
009	Bill denied. Duplicate of a service previously paid to the beneficiary, physician, or hospital.
010	Bill denied. Duplicate of a service still in process within our system.
011	Beneficiary's name/social security number do not match. Correct and resubmit.
012	Service denied. There is no standard diagnosis for code referenced on detail.
013	Beneficiary's social security number is missing. Please complete and resubmit.
014	Prescription number is missing or invalid. Please correct and resubmit.
015	Charge for this service is missing or invalid. Please correct and resubmit.
016	Fee exceeds expected amount. Resubmit with supporting documentation such as usual and customary for your area.
018	Item can only be rented for three months unless there is medical justification. Submit justification and/or purchase price to your district office.
019	Item can only be purchased if need is over three months. Submit justification and/or rental fee to your district office.
020	Our records indicate this item was purchased. Therefore, rental is not covered.
021	Expected number of services has been exceeded. If additional services are required, submit a CMN for pulmonary rehabilitation.
023	A similar procedure has been paid for the same date of service. If justified, resubmit with medical rationale.
029	Procedure/RCC Code billed is inappropriate for services rendered. Please correct and resubmit.
031	Bill was manually priced. Paid per DOL/EEOIC standards.
044	This amount has been applied to an outstanding accounts receivable.
046	Expected number of services has been exceeded. If justified, resubmit with medical rationale.
047	Our records show that the beneficiary is not eligible for Energy Employees Occupational Illness Compensation benefits.
048	Bill denied. Beneficiary's dependents are not eligible for EEOIC medical benefits.
049	This beneficiary's SSN is not on file. Please resubmit bill with the corrected SSN, if appropriate.

<b>Codes contd.</b>	<b>Descriptions contd.</b>
050	Beneficiary's name is missing. Please complete and resubmit.
054	Date of service is prior to 07/31/01, the effective date of program.
078	Services billed do not meet the Energy Employees Occupational Illness Compensation Program requirements for outpatient UB-92 billing.
079	Bill denied. Documentation justifying Observation Room service should be attached to the UB-92 and submitted together.
080	Bill denied. Service exceeds maximum allowable number of hours.
086	Service began before or ended after (overlaps) the approved CMN date ranges.
087	Surgery date must be within the admission and discharge dates.
090	Bill submitted without any services billed. Please complete and resubmit.
091	Type of Service code is missing. Please complete and resubmit.
092	Type of Service code is invalid for procedure. Please correct and resubmit.
094	The From Date of Service is invalid. Please correct and resubmit.
095	Admission date is missing or invalid. Please correct and resubmit.
097	The From Date of Service is missing. Please complete and resubmit.
098	The Through Date of Service is missing. Please complete and resubmit.
099	The Through Date of Service is before the From Date. Please correct the date and resubmit.
100	The primary diagnosis is missing or invalid. Please correct and resubmit.
101	Accommodation reduced to semi-private room rate per DOL/EEOIC standards.
103	Quantity exceeds maximum expected for the procedure performed. Resubmit if medically necessary.
104	Number of visits of service is missing. Please complete and resubmit.
106	This drug is not payable under the Energy Employees Occupational Illness Compensation Program.
107	Drug not covered by the Energy Employees Occupational Illness Compensation Program for date dispensed.
109	The services rendered should be billed on the appropriate form (HCFA-1500 or NCPDP).
110	Number of visits or units of service invalid. Please correct and resubmit.
111	The Procedure Code is missing. Please code with CPT-4.
113	This drug/procedure is not payable with submitted diagnosis.
114	Type of Service/Procedure Code combination is not on file. If valid, resubmit with explanation.

<b>Codes contd.</b>	<b>Descriptions contd.</b>
115	Service is denied. Primary condition treated is not covered under the EEOIC Program.
117	Service denied. Only beneficiary can be paid for services prior to his application for medical benefits.
118	Date of service is prior to beneficiary eligibility date.
119	Please submit drug name with prescription number.
123	Beneficiary is no longer eligible for EEOIC medical treatment benefits.
125	Expected mileage has been exceeded. Resubmit with explanation of need for services from physician.
126	Eligibility discontinued. If this is an error, resubmit with an explanation.
128	Our records indicate that this service was not authorized.
131	Service not covered by the Energy Employees Occupational Illness Compensation Program.
132	Service denied. Please resubmit inclusive charges with fully itemized bill.
134	The EEOIC Program does not reimburse for services billed when provided for the coded diagnosis.
139	Services rendered should be billed on HCFA/OWCP 1500 Form using CPT-4 codes.
142	The principal diagnosis does not support length of stay if related to EEOIC. If rendered for pulmonary condition, resubmit with medical justification.
146	If primary reason for services was for an accepted condition requiring emergency care, recovery room, or surgical procedures, resubmit with appropriate documentation. CPT-4/ICD-9.
147	Primary reason for services rendered does not appear to be an accepted condition. If you wish reconsideration, resubmit with MD's report.
150	Diagnostic conditions must be coded by ICD-9-CM.
151	Unacceptable bill type. Resubmit on UB-92 with charges by RCC/ICD-9-CM Diagnosis Code, CPT or ICD-9-CM significant Procedure Codes, itemized charges, and discharge summary.
170	An itemized bill listing each service with corresponding charge is required. Please attach and resubmit the bill.
172	Please specify the most common semi-private room rate in Block 39 and resubmit.
173	Please itemize all pharmacy charges by eleven-digit National Drug Code (NDC), quantity, drug name prescription number, corresponding charge, and resubmit.
174	Our records indicate that your name is not on our provider file. Please complete and return the attached provider enrollment form.

<b>Codes contd.</b>	<b>Descriptions contd.</b>
177	Provider signature is required. Please sign and date your bill and resubmit.
178	Additional clinical information is needed. Please resubmit the bill with the history and physical, progress notes, discharge summary, and itemized statement.
179	UB-92, admission/discharge summary(ies), and itemized statement are required. Attach the documents together and resubmit.
182	Admission and/or discharge dates in discharge summary do not agree with those in the summary bill. Please clarify and resubmit.
185	The bill is not legible. Please correct and resubmit.
188	Additional clinical information is necessary to process this bill. Please submit the doctor's progress notes.
190	Bill denied. There are no payable lines on the bill.
200	Every procedure/service must be completely itemized in Blocks 24A-G, including individual charges. Please complete and resubmit.
203	Date(s) of service missing or invalid/illogical. Dates for every procedure billed must be stated clearly. Correct and resubmit.
204	Consultant report must be attached to bills for consultations. Please include and resubmit.
205	The Surgical Pathology report must be attached to the bill for pathology services. Please attach and resubmit.
206	Please itemize all drugs and injections by name and match with corresponding charge. Drugs/injections given in combination must be listed separately.
212	The origin and destination locations (home, hospital, etc.) for ambulance transport must be indicated on bill. Please complete and resubmit.
213	Beneficiary's signature/substitute is missing or invalid.
214	The sum of the itemized charges does not equal the total charge. Please complete and resubmit.
233	Injection name(s) must be provided. Please include and resubmit.
237	Individual charges for every procedure must appear on the bill. Please include and resubmit.
249	The bill or portions of the bill are not legible. Please clarify and resubmit.
255	Referring physician name is required and not present. Bill denied.
256	The billing date is not a valid date. Please correct and resubmit.
259	The number of accommodation days is missing or invalid. Please correct and resubmit.
260	Procedure code is missing. Itemize each procedure/service code with CPT-4 or full description of procedure/service.

<b>Codes contd.</b>	<b>Descriptions contd.</b>
261	Every procedure/service must be completely itemized in Blocks 24A-G. Please complete Block 24G and resubmit.
262	The type of service code is missing. Please have doctor or supplier complete Block 24C and resubmit.
267	Fee exceeds expected amount. Resubmit with supporting documentation, such as usual and customary for your area.
268	Service was paid at maximum allowable fee.
269	Not a benefit of the Energy Employees Occupational Illness Compensation Program.
270	Diagnosis not covered, since it is related to traumatic injury. Service may be covered by other insurance.
288	A portion of your reimbursement has been denied because the amount billed exceeds the maximum allowed dollar amount.
307	This National Drug Code (NDC) is not on the EEOIC Drug File. If you wish to resubmit, use an eleven-digit NDC.
310	The summary bill, Emergency Room record and itemized bill must be submitted together. Please resubmit original bill with the missing document(s).
311	Based on the submitted clinical information, your request for reconsideration of payment has been denied.
320	RTD not returned within 90 days. Bill formally denied.
321	Submitted documentation does not adequately justify the excessive services. Bill denied.
322	RTD returned uncorrected or completed with incorrect information. Bill denied.
323	RTD corrected information does not satisfy requirements. Bill denied.
333	RTD was returned unsigned or the signature was either not original or only in initials.
334	Services cannot be billed prior to end date of service.
342	Date(s) of service missing or invalid. Date of service for every service billed must be clear and on the form.
359	Please resubmit with the quantity dispensed.
367	Type of bill (location) is not payable under the Energy Employees Occupational Illness Compensation Program.
369	Amount paid by another source exceeds total EEOIC allowable charges.
370	Service denied. Must have physician's statement with beneficiary's name, address, diagnosis, equipment request, physician's signature/date. (Six months previous acceptable.)
371	Bill denied. Charges previously paid to beneficiary.
372	Bill denied. Charges previously paid to provider.

<b>Codes contd.</b>	<b>Descriptions contd.</b>
373	Service denied. Must have physician's statement with name/address/patient/ equipment request/physician's signature/date.
374	RCC 320 is not payable under the Energy Employees Occupational Illness Compensation Program. A more specific RCC is required.
375	The full or component fee for this service has been paid. Please contact your co-provider.
377	Hospital stay of 3 days or less requires: UB92; admission/discharge summary(ies) or documentation of illness with progress notes; itemized statement.
378	For ambulance service from the hospital to the home, a statement signed by the physician justifying the need for this ambulance transport is required.
400	Internal denial. Unable to process.
401	Automatic adjustment to correct an original payment.
402	Adjusted by a retroactive rate change.
403	Voided retroactive rate adjustment.
404	Adjustment resulting from an original returned check.
405	Void resulting from an original returned check.
406	Adjustment resulting from a personal check.
407	Void resulting from a personal check.
410	Adjustment due to incorrect procedure code, RCC, or National Drug Code originally processed.
411	Void due to incorrect procedure code, RCC, or National Drug Code originally processed.
412	Adjustment due to incorrect charges originally processed.
413	Void due to incorrect charges originally processed.
414	Adjustment due to incorrect quantity/units of services originally processed.
415	Void due to incorrect quantity/units of services originally processed.
416	Adjustment due to incorrect dates of service originally processed.
417	Void due to incorrect dates of service originally processed.
418	Adjustment due to incorrect type of service originally processed.
419	Void due to incorrect type of service originally processed.
420	Adjustment due to incorrect place of service originally processed.
421	Void due to incorrect place of service originally processed.
422	Void due to incorrect payee originally paid.
423	Void due to incorrect bill type originally processed.
424	Void due to incorrect diagnosis code originally processed.
425	Void due to duplicate payment.
426	Void due to no payable lines on the bill.
427	Adjustment due to duplicate payment.

428	Void due to incorrect SSN originally processed.
<b>Codes contd.</b>	<b>Descriptions contd.</b>
434	Automatic adjustment to correct an original payment.
435	Adjusted by a retroactive rate change.
436	Voided retroactive rate adjustment.
437	Adjustment resulting from an original returned check.
438	Void resulting from an original returned check.
439	Adjustment resulting from a personal check.
440	Void resulting from a personal check.
443	Adjustment due to incorrect procedure code, RCC, or National Drug Code originally processed.
444	Void due to incorrect procedure code, RCC, or National Drug Code originally processed.
445	Adjustment due to incorrect charges originally processed.
446	Void due to incorrect charges originally processed.
447	Adjustment due to incorrect quantity/units of services originally processed.
448	Void due to incorrect quantity/units of services originally processed.
449	Adjustment due to incorrect dates of service originally processed.
450	Void due to incorrect dates of service originally processed.
451	Adjustment due to incorrect type of service originally processed.
452	Void due to incorrect type of service originally processed.
453	Adjustment due to incorrect place of service originally processed.
454	Void due to incorrect place of service originally processed.
455	Void due to incorrect payee originally paid.
456	Void due to incorrect bill type originally processed.
457	Void due to incorrect diagnosis originally processed.
458	Void due to duplicate payment.
459	Void due to no payable lines on the bill.
460	Adjustment due to duplicate payment.
461	Void due to incorrect SSN originally processed.
467	Automatic adjustment to correct an original payment.
468	Adjustment by a retroactive rate change.
469	Voided retroactive rate adjustment.
470	Adjustment resulting from an original returned check.
471	Void resulting from an original returned check.
472	Adjustment resulting from a personal check.
473	Void resulting from a personal check.
476	Adjustment due to incorrect procedure code, RCC, or National Drug Code originally processed.
477	Void due to incorrect procedure code, RCC, or National Drug Code originally processed.
478	Adjustment due to incorrect charges originally processed.

479	Void due to incorrect charges originally processed.
<b>Codes contd.</b>	<b>Descriptions contd.</b>
480	Adjustment due to incorrect quantity/units of service originally processed.
481	Void due to incorrect quantity/units of services originally processed.
482	Adjustment due to incorrect dates of service originally processed.
483	Void due to incorrect dates of service originally processed.
484	Adjustment due to incorrect type of service originally processed.
485	Void due to incorrect type of service originally processed.
486	Adjustment due to incorrect place of service originally processed.
487	Void due to incorrect place of service originally processed.
488	Void due to incorrect payee originally paid.
489	Void due to incorrect bill type originally processed.
490	Void due to incorrect diagnosis code originally processed.
491	Void due to duplicate payment.
492	Void due to no payable lines on the bill.
493	Adjustment due to duplicate payment.
494	Void due to incorrect SSN originally processed.

## **Auditable Records**

Providers must maintain records to support bills submitted for reimbursable medical services and supplies provided. Upon request, information from these records will be furnished to the Department of Labor (DOL) or its servicing contractor for auditing to ensure that bills are processed correctly and completely.

False claims, statements, or documents; or concealment of material facts dealing with obtaining payments from the Federal Energy Employees Occupational Illness Compensation Program (EEOICP) are felonies under Public Law 18 USC 1001 and misdemeanors under Public Law USC 941.

## **The Adjustment Process**

Adjustments to paid bills may be requested when an overpayment or underpayment occurs. Adjustments may be initiated by the provider, CSC, or DOL. The following information gives instructions for requesting adjustments to paid bills.

### **Overpayment**

If an overpayment is received from the EEOICP, the provider should refund the overpayment by using one of the following methods:

- **If the entire U.S. Treasury check is in error:** The provider should return the U.S. Treasury check, copy of the Remittance Advice (RA), and a brief letter of explanation to:

U.S. Department of Labor  
Energy Employees Occupational Illness Compensation  
Program  
P.O. Box 77918  
Washington, D.C. 20013-7918

- **If only part of the U.S. Treasury check is an overpayment:** The provider should cash the U.S. Treasury check and send a personal check for the amount of the overpayment. The provider should enclose a copy of the Remittance Advice (RA) and brief letter of explanation and send to:

U.S. Department of Labor  
Energy Employees Occupational Illness Compensation  
Program  
P.O. Box 77918  
Washington, DC 20013-7918

## Underpayment

A provider whose fee for service is partially paid by OWCP, as a result of the application of its fee schedule or other tests for reasonableness in accordance with this part, shall not request reimbursement from the employee for additional amounts.

When an underpayment occurs, the following steps should be followed:

- Cash the U.S. Treasury check.
- Request an adjustment by completing a cover letter notifying the Energy Employees Occupational Illness Compensation Program (EEOICP) of the underpayment. Figure 16 is a sample letter requesting an adjustment that contains all necessary information. The letter *must* contain:
  - Provider number
  - Provider's name and address
  - Patient's name
  - Patient's social security number
  - Date of service
  - Remittance Advice (RA) date
  - Internal control number (ICN) of the bill
  - Reason for underpayment (and amount)
- The bill and RA should be attached to the cover letter.
- A bill must reflect corrections to any billing errors.
- Adjustment Requests should be sent to:

Energy Employees Occupational Illness Compensation Program  
Attention: Correspondence Unit  
P.O. Box 727  
Lanham-Seabrook, MD 20703-0727

If there are any questions regarding the adjustment process (overpayment or underpayment), please call the toll-free number:  
1-866-272-2682

## **Sample Letter Requesting An Adjustment**

Energy Employees Occupational Illness Compensation Program  
Attention: Correspondence Unit  
P.O. Box 727  
Lanham-Seabrook, Maryland 20703-0727

Re: Adjustment Request of a Medical Bill

Dear Correspondence Representative:

This letter is to request an adjustment. I have attached a corrected billing, which shows the changes that are needed to correct my payment. I have also included all attachments and my remittance advice.

My name is: Dr. Smith M.D.  
My address is: 1001 Energy Lane  
Paintsville, KY 20706  
EEOICP Provider #: 123456  
ICN: 2001073101001  
Patient's name: James Energy  
Social Security Number: 100-10-1001  
Date of service: 1/1/2001  
R.A. date: 2/1/01  
Payment amount: \$50.00

I only billed for 1 unit of service and I should have billed for 2 units of service. I am requesting an adjustment to change the units from 1 to 2. I hope this will correct the underpayment that I received. Please contact me at (606) 731-1001 if you have any questions.

Thank you for your assistance.

Sincerely,

*Dr. Smith, M.D.*  
Dr. Smith, M.D.

**Figure 13 - Requesting An Adjustment (Sample Letter)**

## The Resubmission Turnaround Document (RTD)

The Energy Employees Occupational Illness Compensation Program has a process designed, in part, to shorten suspense time by allowing providers to correct some of the bills containing errors and/or omissions without actually returning the bill. This is accomplished through the use of a Resubmission Turnaround Document (RTD). The RTD is used to correct provider-correctable errors, such as invalid procedure code(s) or missing date(s) of service. A sample RTD (**Figure 14 - The Resubmission Turnaround Document (Front)**) appears on the next page, and the following is a description of the form.

If you receive an RTD, examine it carefully. **PART A** contains all the information necessary to identify the bill that contains the errors. This includes the patient's name, social security number, total bill charge(s) and date(s) of service. Errors on the bill are listed in Part A of the form, which is directly below the instructions. Part A contains the following: the **Information Block**, which identifies the location of the error on the bill; the **Submitted Information** (if any); the **Service Code** (CPT-4 procedure code, HCPC, RCC, or NDC); **Error Code**; Identifying Information; and **Patient Name**. The **Cor Info** is used by the provider to record the corrected information entered on Part B of the form for the provider's own record. Directly beneath these blocks is an **Error Description** block, which lists the error code and description of the error.

**PART B** of the RTD is used to record the corrected information so it can be processed by CSC. The provider should examine each error line in Part A and print or type the correct information on the corresponding line under **Correct Information** on the right-hand side of Part B. When this has been done for each error line, **the provider must sign and date the form** in the lower left-hand corner of Part B **and return Part B only** to CSC at the address indicated. Because of the type of processing involved, corrections to RTD information may **not** be called in on the toll-free line. Part A should be retained for the provider's own records.

The RTD should be filled out and returned to CSC as soon as possible, because processing cannot be completed until those errors are corrected. The provider has until the date shown at the top of Part A to return the RTD. If the RTD is not received from the provider in a timely fashion, a final notice will be sent approximately 45 days after the first notice. If no response is received from the provider within 90 days of the date of the first notice, the bill will be systemically denied.

Questions regarding RTDs should be directed to the  
Correspondence/Communication Representative toll-free lines:

1-866-272-2682







B

Form EE-1173  
Rev. Sept. 2005

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**Refers to Government Programs Only**

**MEDICARE AND CHAMPUS PAYMENTS:** A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "insured," i.e., items 3, 6, 7, 8, 9 and 11.

**BLACK LUNG, EEOICP, AND FECA CLAIMS:** The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung, EEOICP, and FECA instructions regarding required procedure and diagnosis coding systems.

**Signature of Physician or Supplier (MEDICARE, CHAMPUS, FECA, EEOICP, and Black Lung)**

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered an "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder. For EEOICP, I further certify that the services performed were for an Energy Employee Occupational Illness related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**Notice to Patient about the Collection and Use of MEDICARE, CHAMPUS, FECA, EEOICP, and Black Lung Information**

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, EEOICP, and BLACK LUNG programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; Public Law 106-398 and 20 CFR 30-701.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations of Federal agencies as necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services renders or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work-related injury, so we can determine whether workers' compensation will pay for treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

**Figure 15 - The Resubmission Turnaround Document (Back)**

## **Billing Inquiries**

### Telephone Inquiries

Communications Representatives are available to answer questions from providers on the toll-free line during the hours of 8:15 a.m. to 4:45 p.m., Eastern Time, Monday through Friday. Questions regarding bill status, billing procedures, Explanation of Benefits (EOB) messages or RTDs should be directed to the toll-free number:

1-866-272-2682

Please have the bill, Remittance Advice (RA), or other correspondence in question in front of you when calling, so that all queries can be answered expeditiously.

If a Communications Representative cannot answer your question immediately, you will be advised that your inquiry will be researched for a later response. In most instances, general questions can be answered immediately.

### Written Inquiries

Correspondence Representatives review and respond to all written correspondence received at CSC in Lanham, Maryland, including billing inquiries and concerns, billing procedure questions, status of bills, supply requests (e.g. enrollment form) and all other written inquiries.

Providers should attach all necessary documentation to written inquiries, so that questions and concerns can be addressed accurately and efficiently.

The Correspondence Unit will respond to all written correspondence in a timely manner. All written inquiries should be addressed to:

Energy Employees Occupational Illness Compensation Program  
Attn: Correspondence Unit  
P.O. Box 727  
Lanham-Seabrook, MD 20703-0727

## **Division of Energy Employees Occupational Illness Compensation (DEEOIC)**

### **District Office Locations**

Questions regarding Beneficiary eligibility, should be directed to the district office where the Beneficiary's claim file is located. The following is a listing of the Department of Labor, DEEOIC district offices.

#### **District Office 1 – Jacksonville, Florida**

(Alabama, Florida, Georgia, Louisiana, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee)

U.S. Department of Labor – DEEOIC  
Employment Standards Administration  
Office of Workers' Compensation Programs  
Division of Energy Employees' Compensation  
214 North Hogan Street, Suite 910  
Jacksonville, FL 32202  
(904) 357-4705 or Toll Free: 1-877-336-4272

#### **District Office 2 – Cleveland, Ohio**

(Indiana, Michigan, Ohio, Illinois, Minnesota, Wisconsin, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey, New York, Puerto Rico, the Virgin Islands, Delaware, Pennsylvania, West Virginia, District of Columbia, Maryland, and Virginia)

U.S. Department of Labor - DEEOIC  
Employment Standards Administration  
Office of Workers' Compensation Programs  
Division of Energy Employees' Compensation  
1001 Lakeside Avenue, Suite 350  
Cleveland, OH 44114  
(216) 802-1300 or Toll Free: 1-888-859-7211

#### **District Office 3 – Denver, Colorado**

(Colorado, Montana, Iowa, Kansas, Missouri, Nebraska, New Mexico, Oklahoma, North Dakota, South Dakota, Utah, Wyoming, Arkansas, Louisiana, and Texas) Note: All claims from RECA Section 5 awardees should be filed in the Denver District office.

U.S. Department of Labor - DEEOIC  
Employment Standards Administration  
Office of Workers' Compensation Programs  
Division of Energy Employees' Compensation  
1999 Broadway Street, Suite 1120  
P.O. Box 46550  
Denver, CO 80201-6550  
(720) 264-3060 or Toll Free: 1-888-805-3389

#### **District Office 4 – Seattle, Washington**

(Alaska, Idaho, Oregon, Washington, Arizona, California, Marshall Islands, Hawaii, and Nevada)

U.S. Department of Labor - DEEOIC  
Employment Standards Administration  
Office of Workers' Compensation Programs  
Division of Energy Employees' Compensation  
719 2<sup>nd</sup> Avenue, Suite 601  
Seattle, Washington 98104  
(206) 373-6750 or Toll Free: 1-888-805-3401

## **Forms and Data Elements**

Required forms for use in medical bill processing for the Energy Employees Occupational Illness Compensation Program (EEOICP) are as follows: UB-92, HCFA-1500, NCPDP Universal Pharmacy Billing, Medical Travel Refund, and beneficiary claim for Medical Reimbursement.

## **Bill Filing Limitations**

The Energy Employees Occupational Illness Compensation Program will reimburse providers promptly for all bills received on an approved form and in a timely manner.

Bills will not be paid for services incurred if the bills are submitted more than one year beyond the end of the calendar year in which the services were incurred or provided.

Example: Services provided on 03/02/02.  
Bill must be filed by 12/31/03.

No services paid prior to 07/31/01 (Program Recognition Date).

## **Billing Tips**

The following are items identified by the Energy Employees Occupational Illness Compensation Program (EEOICP) that can cause bill processing delays and denials. Providers are encouraged to review these items and take note of billing requirements.

## **Tips for All Providers**

Provider ID

The six-digit DOL Provider Number must appear clearly in the appropriate block on all billing forms (e.g., Block 51 of the UB-92, Block 33 of the HCFA-1500 and Block 7 of the NCPDP Universal Pharmacy Form). It must be included on all written correspondence and related attachments.

Beneficiary ID	The Beneficiary's Social Security Number must appear on all billing forms (e.g., Block 60 of the UB-92, Block 1A and 11 of the HCFA-1500, and Block 2 of the NCPDP Universal Pharmacy Form). The Beneficiary's Social Security Number must also be included on all written correspondence and related attachments.
Provider Signature and Date	The provider's signature and date must appear in (e.g. Blocks 85 and 86 of the UB-92, Block 31 of the HCFA-1500 and Block 10 of the NCPDP Universal Pharmacy Form). Signatures produced by rubber stamps or data processing equipment are acceptable.
Patient Signature and Date	The patient's signature or signature substitute and date signed must appear in Block 12 of the HCFA-1500. The patient's signature or signature substitute must also appear in Block 13. Entering "Signature on File" in Blocks 12 and 13 are acceptable if the provider actually has the signature on file and indicates this in all appropriate Blocks.
Dates of Services	<p>Both "From" and "To" dates must appear in Block 6 of the UB-92 form. "From" and "To" dates should also be used in Block 24A of the HCFA-1500 if billing for the same procedure or service on consecutive days and Block 8 of NCPDP Universal Pharmacy Form. Dates of service must not overlap when billing for the same procedures or services for the same patient. For example, when billing for rental of equipment for January through February, <i>do not</i> complete the dates of service as:</p> <p style="padding-left: 40px;">1/1/88-1/31/88 1/31/88-2/28/88</p> <p style="padding-left: 40px;">The <i>correct</i> entries should be:</p> <p style="padding-left: 40px;">1/1/88-1/31/88 2/1/88-2/28/88</p>

Diagnosis Codes and  
Procedure Codes

All diagnosis codes must be ICD-9-CM diagnosis codes. All procedure codes must be CPT-4, HCPCS and NDC codes. On all UB-92 forms, all principal procedures and other procedures performed during a hospitalization must be coded with ICD-9-CM codes. On all HCFA-1500 billings (except pharmacy), every procedure code must have a corresponding diagnosis code. The procedure code should be entered in Block 24D of the HCFA-1500. The diagnosis code(s) should be entered in Block 21. Reference to the specific diagnosis code(s) associated with each procedure code must be indicated in Block 24E.

Place of Service and Type of Service  
Codes

All HCFA-1500 billings (except pharmacies) must include Place of Service (POS) and Type of Service (TOS) codes. The POS code must appear in Block 24B and the TOS code must appear in Block 24C of the HCFA-1500.

Billing Dates and  
Dates of Service

The date the bill is signed is considered to be the billing date. A service rendered cannot be billed until that service has been provided. The dates of service must not be later than the date the billing form was signed. Billing forms must not be post-dated.

Maximum Billing Lines

Each HCFA-1500 can be used to bill a maximum of six lines. *Do not* insert additional lines. Use multiple forms if necessary. Each HCFA-1500 form must include a "Total Charge" and "Balance Due."

Handwritten Bills

Handwritten bills on the Required forms are acceptable. However, legibility is crucial to accurate processing.

National Drug Code

Pharmacy bills submitted on the HCFA-1500 and the NCPDP Universal Pharmacy Billing Form must contain the 11 digit NDC for each drug billed.

## **Where to Order Forms**

### **HCFA-1500:**

Government Printing Office  
Superintendent of Documents  
P.O. Box 371954  
Pittsburgh, PA 15250-7954

Washington: (202) 512-1800  
Toll Free: 1-866-512-1800

American Medical Association  
P.O. Box 930876  
Atlanta, GA 31193  
(800) 621-8335

### **UB-92:**

(Providers should contact one of the following offices in their area.)

American Hospital Association  
State Hospital Association  
State Uniform Billing Committee  
Standard Register Printing Company

### **Provider Enrollment Forms:**

Energy Employees Occupational Illness Compensation Program  
ATTN: Correspondence Unit  
P.O. Box 727  
Lanham-Seabrook, MD 20703-0727  
1-866-272-2682

## Technology For Capturing Medical Bill Data

The Energy Employees Occupational Illness Compensation Program (EEOICP) will be using a digital imaging and optical character recognition (OCR) document and data capture system for processing of medical bills.

The OCR system provides a more accurate and expedient method for capturing and processing medical bill data. It represents a proven technology that allows medical bill data to be read electronically, thus eliminating the need for traditional keypunch or direct data entry. Many other payors of medical benefits are also utilizing this technology. Under the OCR system, the medical bills will be scanned and converted to digital images for processing and adjudication purposes.

To assist with timely and accurate bill processing, please adhere to the following guidelines for completing medical bills prior to submission to the EEOICP. Failure to comply with these guidelines may result in processing delays.

### DO:

- **Use typewritten characters (10 pitch or 12 point type)**
- **Use standard dot matrix or laser fonts (Courier or Times Roman)**
- **Use uppercase (CAPITAL) letters throughout**
- **Enter all information within the required fields**
- **Align forms carefully for proper data placement**
- **Correct mistakes by**
  - applying liquid paper
  - using white carbon correcting paper
  - erasing neatly
- **Remove pin feed edges evenly at side perforation**
- **Use black or blue ink**
- **Submit the original bill form for processing**

### DON'T:

- Use red ink
- Add unnecessary staples or paper clips to attach supporting documentation
- Mix character fonts on the same form
- *Use italicized, script, or slant type fonts*
- Use old or worn print bands, cartridges, or ribbons
- Print, handwrite, or stamp extraneous data on the form
- Strike or trace over a character
- Submit carbon copies of the bill form for processing
- Photocopy the bill to enhance the quality
- Handwrite billing information on the form

If you have any questions regarding this technology or proper billing form submission, please contact our toll-free information line at 1-866-272-2682. Our representatives will be available to assist you Monday through Friday, between the hours of 8:15 a.m. and 4:45 p.m., Eastern Time.

## **Claim Filing – Procedures for Claim Submission**

It is required by specific regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to process claims in a timely manner. When required data and/or information is missing or invalid, claims will be rejected by the Processing Center and a correction and/or resubmission may be required.

Claims filed are subjected to the following procedures:

- Verification that all required fields is completed on the UB-92, HCFA-1500 and NCPDP Pharmacy forms.
- Verification of all Procedure and Diagnosis Codes are valid for the Date of Service (DOS)
- Verification of member eligibility for services under the Plan during the time period in which services were provided.

## **Common Causes of Claim Processing Delays, Rejections, or Denials**

Listed below are some common causes in which claims will have to be corrected and/or resubmitted. Not all claims are filed in the same manner. This list is to show the common mistakes when filing claims.

- Billed Charges – Missing or Incomplete  
Note: Each bill must have a total charge indicated. “Continued” is not acceptable.
- Diagnosis Codes – Missing / Invalid Digits  
  
Example: A patient has respiratory conditions due to other and unspecified external agents. You as the provider, write down 508.0 (which stands for “Acute pulmonary manifestations due to radiation”). The actual code is 508, not 508.0. Please be aware that EEOICP pays according to accepted conditions.
- DRG Codes – Missing or Invalid  
Note: Hospitals contracted for payment based on DRG must include this information on the billing form.
- Handwritten Forms – Illegible
- Incomplete Forms
- Payer or Other Insurer Information – Missing or Incomplete
- Provider Names - Missing
- Provider Identification Number - Missing or Invalid  
**(Unique 6 digit DOL Provider Number)**
- Revenue Codes - Missing or Invalid
- Signature - Missing  
Note: Handwritten, stamped or computer generated names will be accepted.
- Tax Identification Number - Missing or Invalid

## Beneficiary Reimbursement Request Forms

Beneficiaries are required to complete standardized forms when seeking reimbursement for out-of-pocket expenses covered under the Energy Employees Occupational Illness Compensation Program (EEOICP). These forms are the Beneficiary Medical Travel Refund Request Form (OWCP-957) and the Beneficiary Medical Reimbursement Form (EE-915).

Beneficiaries may obtain reimbursement forms and answers to questions regarding submission of bills for reimbursement of out-of-pocket expenses and bill payment status by calling the following toll-free number:

1-866-272-2682

### Medical Travel Refund Request Form OWCP-957

The beneficiary is responsible for completion and submission of the Medical Travel Refund Request Form OWCP 957. **See Figure 16 - Medical Travel Request Form (Front)** Instructions for completing the form in accordance with DOL requirements are on the reverse side of the form. **See Figure 17 - Medical Request Form (Back)**

The form is completed by the beneficiary for reimbursement of expenses incurred while traveling for medical treatment or medication for accepted condition(s). The beneficiary is requested to complete Block(s) 5a, b, c, d, e, f, g, and block 8.

- Enter claimant's full name, last name, middle initial
- Enter claimant's Social Security Number
- Enter payee's full name if different from claimant's name
- Claimant's/Payee's Address
- Date of Travel
- One-way or Round Trip
- Travel From
- Travel To
- Medical Facility Name and Address
- Private Auto Only (Miles traveled)
- Beneficiary Signature and Date

Medical Travel Refund Request		<b>U.S. Department of Labor</b> Employment Standards Administration Office of Workers' Compensation Programs		 OMB No. 1215-0054 Expires: 06/30/2004
<small>NOTE: This report is authorized by the Black Lung Benefits Act (30 USC 901, 20 CFR 725.406 and 725.701) and the Energy Employees Occupational Illness Compensation Program Act (Public Law 106-398 and 20 CFR 30.701). While you are not required to respond, this information is required to obtain reimbursement for travel expenses. The method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974 and OMB Circ. 108. This form should be used for medically related services covered under the Federal Black Lung Program and the Energy Employees Occupational Illness Compensation Program.</small>				
1. Claimant's Name (Last, first, MI.): <b>Smith, Charles P.</b>			2. Social Security Number: <b>999-99-9999</b>	
3. Payee's Name if different from claimant's name (last, first, MI.): (See instruction no. 3 on the back of form)				
4. Claimant's/Payee's Address (Street/RFD, City, State, Zip Code): <b>319 Jefferson Drive, Tunnelsport, PA 1660</b>				
<b>Special Instructions:</b> 1. See reverse side of form for complete instructions and attachment of receipts. 2. Physician's signature or facsimile is <b>REQUIRED by BLACK LUNG</b> for verification of each service date and type.				
5a. Date of Travel: <b>09/27/2001</b>		f. Total expense/cost: <b>DOL USE ONLY</b> <b>TOS/Procedure Code</b> \$ _____		
b. <input type="checkbox"/> One-way <input checked="" type="checkbox"/> Round Trip		<b>FOR BLACK LUNG USE ONLY</b> h. To be completed by Physician: (Mark one box only) Care Rendered <input type="checkbox"/> Treatment for Black Lung <input type="checkbox"/> Not Black Lung Related <input type="checkbox"/> Determine, Test for Black Lung Diagnosis _____ _____ (Signature of Physician) _____ (Date Care Rendered)		
c. Travel From: <input type="checkbox"/> Hospital <input checked="" type="checkbox"/> Office/clinic <input type="checkbox"/> Lab <input checked="" type="checkbox"/> Home		d. Travel To: <input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Office/clinic <input type="checkbox"/> Lab <input type="checkbox"/> Home (Specify) _____		
e. Medical facility name and address: <b>Community Health CTR 1 Main Street Tunnelsport, PA 1660</b>		g. Private Auto Only Miles traveled: <b>23</b> Total \$ _____		
6a. Date of Travel:		f. Total expense/cost: <b>DOL USE ONLY</b> <b>TOS/Procedure Code</b> \$ _____		
b. <input type="checkbox"/> One-way <input type="checkbox"/> Round Trip		<b>FOR BLACK LUNG USE ONLY</b> h. To be completed by Physician: (Mark one box only) Care Rendered <input type="checkbox"/> Treatment for Black Lung <input type="checkbox"/> Not Black Lung Related <input type="checkbox"/> Determine, Test for Black Lung Diagnosis _____ _____ (Signature of Physician) _____ (Date Care Rendered)		
c. Travel From: <input type="checkbox"/> Hospital <input type="checkbox"/> Office/clinic <input type="checkbox"/> Lab <input type="checkbox"/> Home		d. Travel To: <input type="checkbox"/> Hospital <input type="checkbox"/> Office/clinic <input type="checkbox"/> Lab <input type="checkbox"/> Home (Specify) _____		
e. Medical facility name and address:		g. Private Auto Only Miles traveled: _____ Total \$ _____		
7a. Date of Travel:		f. Total expense/cost: <b>DOL USE ONLY</b> <b>TOS/Procedure Code</b> \$ _____		
b. <input type="checkbox"/> One-way <input type="checkbox"/> Round Trip		<b>FOR BLACK LUNG USE ONLY</b> h. To be completed by Physician: (Mark one box only) Care Rendered <input type="checkbox"/> Treatment for Black Lung <input type="checkbox"/> Not Black Lung Related <input type="checkbox"/> Determine, Test for Black Lung Diagnosis _____ _____ (Signature of Physician) _____ (Date Care Rendered)		
c. Travel From: <input type="checkbox"/> Hospital <input type="checkbox"/> Office/clinic <input type="checkbox"/> Lab <input type="checkbox"/> Home		d. Travel To: <input type="checkbox"/> Hospital <input type="checkbox"/> Office/clinic <input type="checkbox"/> Lab <input type="checkbox"/> Home (Specify) _____		
e. Medical facility name and address:		g. Private Auto Only Miles traveled: _____ Total \$ _____		
8. Payee's Certification: I hereby certify that the information given by me on and in connection with this form is true and correct to the best of my knowledge and belief. I am also fully aware that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this title shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine of not more than \$1,000, or by imprisonment for not more than one year or both.				
Claimant's/Payee's Signature: <i>Charles P. Smith</i>			Date: <b>10/01/2001</b> <small>Form DWCP-957 Rev. Aug 2001</small>	

**Figure 16 - Medical Travel Request Form (Front)**

### Instructions (Form OWCP-957)

1. Enter claimant's full name: last name, first name, middle initial.
2. Enter claimant's Social Security Number.
3. Enter payee's full name (if person other than the miner or claimant is to be reimbursed): last name, first name, middle initial.  
A payee other than the claimant must have special authorization.

Please explain the following:

- a. Relationship to the claimant \_\_\_\_\_
- b. The reason you are requesting reimbursement \_\_\_\_\_

4. Enter the address of the person to be reimbursed. The address is to include:  
Street/RFD, City, State, Zip Code

- 5, 6, and 7. Complete a separate block for each medical facility visited on the same day. For travel on different days, complete one block for each date.

- a. Enter date of travel.
- b. Mark one box only.
- c. Mark one box only.
- d. Mark one box only.
- e. Enter the name and address of the medical facility.
- f. Mark each box for which you are claiming reimbursement and list the amount of money spent for each item.
- g. Enter the total number of miles traveled by private automobile.
- h. The physician or designee is to complete this item.

8. The person claiming reimbursement must sign here.

**Attach all original receipts for expenses listed in 5f, 6f, and 7f. The claimant's full name and Social Security Number should appear on each receipt.**

#### FOR BLACK LUNG USE ONLY

- Note:**
- Only travel expenses for the miner are reimbursable
  - Special approval from the district office is needed for lodging or for travel exceeding 75 miles one way or 150 miles roundtrip.
  - To obtain your district office telephone number, 1-800-638-7072.
  - Reimbursement for meals will be made only when authorized travel exceeds 24 hours or under special circumstances.
  - Travel to pick up medicine, equipment or supplies is not reimbursable.

#### FOR ENERGY EMPLOYEES ONLY

- Note:** Special approval from the district office is needed for travel exceeding 75 miles one way or 150 miles roundtrip. To obtain your district office telephone number, call toll free 1-866-272-2682.

#### Public Burden Statement

We estimate that it will take an average of 10 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Office of Workers' Compensation, Room C3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

**NOTE:** Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

**Figure 17 - Medical Request Form (Back)**

## **Beneficiary Medical Reimbursement Form EE-915**

Beneficiaries are to complete Form EE-915 when seeking reimbursement of out-of-pocket expense for medical treatment, prescription medication, and medical supplies relating to the accepted condition. **See Figure 18- Claim For Medical Reimbursement Form (Front)** Beneficiaries may request assistance with completing Form EE-915 by calling toll-free 1-866-272-2682. Instructions for completing the form in accordance with DOL requirements are on the reverse side of the form. **See Figure 19 - Claim For Medical Reimbursement Form (Back)**

In addition to submitting the completed EE-915 Beneficiary Medical Reimbursement form, the beneficiary must submit proof of cost and payment. Either an itemized bill on the provider's letterhead or the provider's official receipt is required. Both must be signed by the physician or an authorized representative, include a written description of service, date(s) of service, diagnosis(es), and charge for each type of service or supply provided. The EE-915 form must be submitted, with documentation showing proof of payment for the services/supplies listed on the EE-915.

Beneficiary reimbursement of prescription drugs must be submitted on the pharmacist's original letterhead that includes the beneficiary's name, date purchased, National Drug Code (NDC) and charge for each drug, and amount actually paid by the beneficiary or authorized payee representative for the drugs listed on the EE-915. The address and social security number of the beneficiary, the name of the physician who prescribed each drug, the amount prescribed (MGM/ML, CC, tablet) per prescription must be on the original receipt. An itemized list or computerize out on the pharmacy's letterhead is acceptable, providing it is signed by the pharmacist, and states who paid and includes all data on the original receipts.

Reimbursement of inpatient hospital expenses, an admitting diagnosis(es), a summary of charges (UB 92), and an admission/discharge summary are required in addition to an itemized bill and a completed EE-915 form.

**Claim for Medical Reimbursement Under  
Energy Employees Occupational Illness  
Compensation Program Act**

U.S. Department of Labor  
Employment Standards Administration  
Office of Workers Compensation Programs



Provide all information requested below. **DO NOT FILL IN SHADED AREAS.** Read the attached information in order to ensure the submission of all required documentation. Maintain a copy of all documentation for your records.

OMB No.: 1215-0147  
Expires: 7/31/2004

**PERSONAL INFORMATION**

Name <b>Smith, Charles P</b>			EEOICPA Case File Number <b>9 9 9 9 9 9 9</b>
Last	First	M.I.	
Address <b>319 Jefferson Drive</b>			Telephone Number <b>(814) 999 - 0124</b>
Street/P.O. Box/Apt No. <b>Tunnelsport, PA 16600</b>			<b>FOR DOL USE ONLY</b>
City	State	Zip Code	

**PROVIDER INFORMATION**

Name of Doctor's Office, Hospital, Pharmacy or Medical Supply Company where expense was incurred. (A separate EE-915 must be filed for each provider)

**J.C. Wazab, M.D.**

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM, DD, YY)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
<b>Office Visit</b>	<b>09/27/2001</b>	<b>09/27/2001</b>	<b>35.00</b>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

Total Reimbursement  
**\$ 35.00**

I certify that the information above is correct and that the reimbursement requested is for expenses paid by me for the treatment of my covered illness or disease. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain compensation under the EEOICPA is subject to civil penalties and/or criminal prosecution.

I authorize any provider named above to release information to the US Department of Labor, OWCP if necessary for the proper adjudication of this claim.

Signature *Charles P. Smith* Date 10/01/2001

Form EE-915

**Figure 18- Claim For Medical Reimbursement Form (Front)**

### CLAIM FOR MEDICAL REIMBURSEMENT

- Under EEOICPA, you are eligible to seek reimbursement for out of pocket medical expenses pertaining to the treatment of an accepted covered illness or disease. The EE-915 form can be used to seek reimbursement for expenses in regard to medical treatment, prescription medication and medical supplies.
- Please submit a separate reimbursement claim for each provider where an out of pocket expense was incurred.
- Please print clearly and legibly. Reference your EEOICPA claim file number on all documentation submitted to the District Office. Maintain a copy of the completed EE-915 form and supporting documentation for your records.

### DOCUMENTATION REQUIRED FOR MEDICAL REIMBURSEMENT

#### Prescription Medication

1. Completed EE-915
2. A Universal Health Claim form (NCPDP Form 79-1A) or equivalent, which must be attached to the EE-915 and must include the following information:
  - a. Name, address and telephone number of pharmacy
  - b. Tax identification number for pharmacy
  - c. Name of doctor issuing prescription
  - d. Name of medication
  - e. Date of purchase
  - f. Eleven Digit National Drug Code (NDC#)
  - g. New prescription or refill number
  - h. Quantity of medication (e.g. # of pills or ml/cc)
  - i. Amount paid by employee per medication
3. Proof of payment indicating that the employee or authorized payee rendered payment for the claimed charges. Proof of payment can include cash receipt, cancelled check or credit card slip.

#### Medical Expense for Treatment of Accepted EEOICPA Condition (Other than prescription medication):

1. Completed EE-915
2. Physicians and other health care providers (i.e. physical therapists) must complete form HCFA 1500. Hospitals and other facilities, such as ambulatory surgical centers, skilled nursing facilities, etc. must submit their bills on Form UB 92. Every form must be completed in its entirety in the same manner as bills submitted by the provider directly to the EEOICPA. The amount paid by the claimant must be indicated. The HCFA-1500 or UB-92 must be attached to this form. It is the responsibility of the person submitting a claim for reimbursement to obtain a completed HCFA-1500 or UB-92 from the provider rendering service. Without a fully completed HCFA-1500 or UB-92, the OWCP is not able to process a reimbursement.
3. Proof of payment indicating that the employee or authorized payee rendered payment for the claimed charges. Proof of payment can include cash receipt, cancelled check or credit card slip.

#### Travel

Do not use form EE-915 to submit a claim for travel reimbursement. Claims for travel reimbursement should be submitted on OWCP-957, "Medical Travel Refund Request."

### Public Burden Statement

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim form to this address. Completed claims are to be submitted to the appropriate regional District Office of Workers' Compensation Programs. Persons are not required to respond to this information collection unless it displays a currently valid OMB number.

Figure 19 - Claim For Medical Reimbursement Form (Back)

## Scenario #1- UB-92 Inpatient Forms

93

## **Scenario # 2 - UB-92 Inpatient Forms**



Kendville Hospital 6985 South Street Price, UT 84501 (865)650-1679		2		3 PATIENT CONTROL NO		4 TYPE OF BILL 131	
5 FED. TAX NO.		6 STATEMENT OF SERVICE PERIOD FROM		7 PERIOD TO		8 FOLD	
624786985		12/10/01		12/10/01		1	
12 PATIENT NAME Carson, Bruce				13 PATIENT ADDRESS 98 North Main Ave., Elmo, UT 84521			
14 BIRTHDATE 12/10/01		15 SEX M		16 DATE OF ADMISSION 12/10/01		17 HOSPITAL STAY 01	
18 OCCURRENCE DATE		19 OCCURRENCE DATE		20 OCCURRENCE DATE		21 OCCURRENCE DATE	
22 OCCURRENCE DATE		23 OCCURRENCE DATE		24 OCCURRENCE DATE		25 OCCURRENCE DATE	
26 OCCURRENCE DATE		27 OCCURRENCE DATE		28 OCCURRENCE DATE		29 OCCURRENCE DATE	
30 OCCURRENCE DATE		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
U.S. DOL - OWCP - EEOICPA							
42 REV CD		43 DESCRIPTION		44 HCPCS / RATES		45 SERV DATE	
250 Pharmacy				12/10/01		1	
270 MED-SURG Supplies				12/10/01		3	
410 RESPIRATORY SVC		94664		12/10/01		1	
450 EMERG ROOM		9928325		12/10/01		1	
730 EKG / ECG		93005		12/10/01		1	
985 PRO FEE / EKG		93010		12/10/01		1	
001 Total Charges						345.96	
50 PAYER		51 PROVIDER NO.		52 PRIOR PAYMENTS		53 EST AMOUNT DUE	
U.S. DOL - OWCP - EEOICPA		365874		345.96			
57		DUE FROM PATIENT					
58 INSURED'S NAME		59 CERT. - SSN - HC - ID NO		61 GROUP NAME		62 INSURANCE GROUP NO.	
		698-85-1563					
63 TREATMENT AUTHORIZATION CODES		64 EMPLOYER NAME		65 EMPLOYER LOCATION			
67 PRINT DATE		68 DATE		69 DATE		70 DATE	
491.21							
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## Scenario #1 - NCPDP Universal Pharmacy Billing Forms

GROUP NO.		<input type="checkbox"/> <b>Energy Employee Compensation Program</b>		CARDHOLDER I.D. NO.		123456789		OTHER THIRD PARTY COVERAGE		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		FOR OFFICE USE ONLY	
CARD-HOLDER NAME		Harris, Paul		LAST		FIRST		INITIAL					
PHARMACY INFORMATION				PATIENT LAST NAME				FIRST & INITIAL		DATE OF BIRTH		SEX	
NAME				CVS Pharmacy				Harris, Paul		06 12 1950		x x	
STREET NO.				1802 Main Street								7.50	
CITY				Jacksonville, FL 36632								NCP COST	
STATE & ZIP												DISP FEE	
PHONE NO.				567890				DATE FILL WRITTEN		06 05 01		TAX	
PHONE				800-648-2993				DATE FILL FILLED		01 09 03		TOTAL PRICE	
								AUTHORIZED PHARMACY REPRESENTATIVE		X <i>Jim Carter R. PH</i>		7.50	
RX NUMBER				1628568				NATURAL DRUG CODE		00009 0045 01		AM5535767	
NDC				R 5 MG 60				LABELER NO.		00009		PROD. NO.	
QUANTITY				60				PRES.		01		AM5535767	
DATE SUPPLY								PRESCRIBER IDENT.		01		BAL.	
2													

## Scenario #2 - NCPDP Universal Pharmacy Billing Forms

GROUP NO.		Energy Employees Occupational Illness Compensation Program		CARDHOLDER I.D. NO.		123456789		OTHER THIRD PARTY COVERAGE		FOR OFFICE USE ONLY	
CARD-HOLDER NAME		Hart, Peter		LAST FIRST		INITIAL		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
PHARMACY INFORMATION				PATIENT LAST NAME FIRST & INITIAL DATE OF BIRTH SEX RELATIONSHIP TO CARDHOLDER							
NAME Rite-Aid				Hart, Peter				06 12 1950		x x	
STREET NO. 1802 Main Street											
CITY, STATE & ZIP Jacksonville, FL 36632											
PHONE NO. 555120				DATE RUS WRITTEN 11 02 02				200.00		NCP COST	
				DATE RUS FILLED						DISP FEE	
PHONE 800-648-2994				X Jan Simons R. PH						TAX	
RX NUMBER		NR	METRIC QUANTITY	DOSE SUPPLY	NATIONAL DRUG CODE LABELER NO.	PRODUCT NO.	PKG	PREScriBER IDENT.	DATE	200.00	TOTAL PRICE
1628568		N	5 MG	60	00638	29198	01	AM5535767			DISC AMT
2											BAL.